DOCTOR OF HEALTH (DHEALTH)

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Abstract

In many countries across sub-Saharan Africa, health inequities are widely prevalent, particularly for poor children who are at higher risk of ill-health and death, if critical child survival interventions are not accessible. Although there has been previous research carried out on the existence of health inequities and the possible strategies required to address them, there is relatively limited research that has specifically focused on the implementation of these policies and programmes (Scott et al., 2012).

The purpose of this study is to explore how preventive health care services have been structured for reaching the poor. The specific aim is to understand the extent to which equity issues have been considered in the planning and implementation of a key programme of the Ministry of Health of Ghana, the Community Growth Promotion (CGP) Programme.

A qualitative case study of CGP was carried out using health policy analysis. In-depth interviews were conducted with stakeholders involved in CGP at the national, sub-national and community levels, and focus group discussions were undertaken with caregivers of children less than five years of age. The sub-national data were collected from the Central Region of Ghana. The interviews were transcribed and analysed using the framework approach (Ritchie & Spencer, 1994).

The key findings of the study focused on three themes: philosophy of equity; analysis of equity issues in CGP, and uptake of health interventions amongst the poor. Health inequities were widely recognised by stakeholders; however there were different drivers and different responses to equity issues at the national and sub-national levels. Although equity was not the foremost consideration in planning and formulating the CGP, it was indirectly addressed in content, focus and structure of the programme. The study further revealed that there are household, community, health service provision and health policy implementation factors that affect the delivery and uptake of services among the poor. In doing so, this thesis contributes to

the literature on health equity and provides guidance for developing countries on implementation of strategies to improve health outcomes for the poor.

List of Abbreviations

CGP - Community Growth Promotion

CHPS – Community Health Planning Services

GSK – Glaxo Smithkline

GEGA – Global Equity Gauge Alliance

iCCM – Integrated Community Case Management

IMCI - Integrated Management of Childhood Illness

NHIS – National Health Insurance Scheme

OOP – Out-of-pocket payment

QR – Qualitative Research

USAID - United States Agency for International Development

1. Introduction to the Study

1.1 Poverty and Health Inequities

1.1.1 Background to Health Inequities

The association between poverty and ill-health is well documented, with poor countries having worse health outcomes compared to richer ones and within countries, rich people having better health than the poor (Wagstaff, 2002). The relationship between poverty and health is bi-directional, with poor people having a higher risk of ill-health, as well as ill-health tipping people into poverty. There are several dimensions of poverty including monetary, housing, health, education and food (Haughton & Khandker, 2009). Poverty can also be characterised in absolute or relative terms. Persons living below a certain level of consumption or income, such as the "proportion of the population below $1 per day", are considered poor (UNDP, 2003). Poverty can also be specified based on the national wealth quintiles, whereby those in the lowest 20th, 33rd or 40th quintile are classified as poor (Rutstein & Johnson, 2004). The disparities in health status and health care occur across the socioeconomic as well as political, ethnic and cultural strata of society. These disparities are referred to as health inequalities and when they are avoidable are referred to as health inequities (Marmot, 2007). Health inequities can be described in regards to health status as well as in relation to health care. Ensuring equity, therefore, requires that there is equal access to the available care for equal need, equal utilisation for equal need and equal quality of care for all (Whitehead, 1992).

Even though ensuring equity in health care delivery is a major goal of health systems across the world, this has not been achieved (Marmot, 2005). The evidence shows that whilst the poor children bear the higher burden of ill-health and mortality, they have less access to interventions (Zere & McIntyre, 2003; Fotso, 2006; Fenn et al., 2007; Hertel-Fernandez et al., 2007; Van de Poel et al., 2007; Gupta & Thakur, 2008; McGillivray et al., 2009). Interventions such as Integrated Management of Childhood Illness (IMC) which are relevant for the poor, do

not reach them (Gwatkins, 2006). Reducing health inequalities would therefore require health services that effectively reach the poor and deliver the required interventions. Addressing these health inequalities is critical to achieving universal health coverage for child health interventions (Were et al., 2015).

1.1.2 Poverty and Health Inequities in Ghana

Ghana is a lower-middle income country with a projected population of 27,670,174 for the year 2015 (Ghana Statistical Service, 2016). Ghana characterizes poverty by lower and upper poverty lines which denote the limits for extreme poverty and overall poverty respectively. The lower and upper poverty lines for 2013 were equivalent to $1.10 and $1.83 per day respectively; and according to this criteria, 24.2% of the population were poor (Ghana Statistical Service, 2014), indicating a relatively high rate of poverty nationally. The incidence of poverty varies across the demographic as well as geographic areas with rates more than three times higher in the rural compared to the urban areas. Amongst the rural areas, poverty is highest in the rural savannah, followed by the rural coastal and by the rural forest. Poverty is highest in the northern regions of the country which are mainly rural savannah, and this trend has persisted over several years (Ghana Statistical Service, 2014; Ghana Statistical Service, 2007). In the southern part of the country, the rates of poverty tend to vary with the years. In 1998/99, the Central Region was the poorest region in the southern part of the country, with the prevalence of poverty of 48% (Ghana Statistical Service, 2007). By 2012 /2013, this figure was down to approximately 20%; however there were variations in the poverty rates in the different districts (Ghana Statistical Service, 2014).

Poverty in Ghana, like other countries is associated with poorer health outcomes. The Demographic and Health Survey (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International, 2015) showed that the risk of dying among children below age five was higher in the poorest quintile compared to the fourth and highest wealth quintiles. Similarly, the prevalence of malnutrition – stunting - was almost thrice as high in the poorest households

compared to the wealthiest households. The children in the poorest households had less access to sanitation facilities and thus had higher prevalence of diarrhoeal diseases. Access to health care and coverage of some interventions is lower amongst the poorest quintile compared to the wealthiest quintile. Forty-seven percent (47%) of the poor are assisted by skilled health professional at delivery compared to ninety-seven percent (97%) amongst the richest quintile. For immunisation coverage, the percentage of children who had received age appropriate vaccinations increased with increasing wealth quintiles.

The high levels of poverty, considered a key challenge to growth and development of Ghana, has been a national priority for over two decades. The *Ghana Poverty Reduction Strategy 2003-2005 An Agenda for Growth and Prosperity Volume I: Analysis and Policy Statement* (Government of Ghana, 2013) indicated the government's concern about the deepening poverty and associated vulnerabilities, exclusion and poor health outcomes particularly in the northern part of the country and the Central Region. Poverty reduction was therefore one of the key goals of the government. This document further outlined as one of its aims removing obstacles to access and utilisation of health care by the poor, bridging gaps in access to services and ensuring sustainable financial arrangements that protect the poor and enhancing efficiency in service delivery. The focus on addressing poverty has therefore been a priority of the Government of Ghana.

Addressing health inequities is also a key consideration of the Health Sector in Ghana. The Ministry of Health, Ghana, in its Five Year Programme of Work: 2007-2011 had as one of the four strategic objectives, "rapid scaling up within the existing capacity, high impact interventions and services, targeting the poor, disadvantaged and vulnerable groups" (Ministry of Health, 2008). The community growth promotion (CGP) programme which was being implemented in the country fell within this category of "high impact interventions and services targeting the poor, disadvantaged and vulnerable groups". The 2013 Programme of Work of the Ministry of Health, Ghana, has included in its policy thrust the reduction of inequities in access

to care (Ministry of Health, 2013). Addressing the health of the poor and marginalised was therefore a major policy goal for the government.

1.2 Brief Review of the Literature Addressing Health Inequities

There have been various studies addressing health inequities, in general, as well as some focusing on addressing health inequities in children, in particular. These include studies that confirm the existence of the inequities in health status and health service coverage across the socioeconomic groups and that identify the determinants leading to these inequities (Victora et al., 2006; Wagstaff et al., 2004). The literature from these studies indicates that despite the availability of known preventive and curative interventions for addressing the problem, they fail to reach many poor children on account of the barriers they face in accessing health services. In response to these barriers, there have been several studies carried out to identify the strategies and interventions that are effective in reaching the poor with health services (Gwatkin, et al., 2005; Anwar, et al., 2005; Owusu-Addo & Cross, 2014). These include interventions to improve service delivery to the poor, such as the use of community-based strategies, integrated delivery of services as well as restructuring of the financial mechanisms to reduce the financial barriers to care for the poor, through health funds, health insurance and exemption schemes, along with other broader interventions outside the health sector. These interventions have shown varying levels of success in the differing settings in which they have been applied. There have been other approaches that have applied the evidence from monitoring of inequities as a catalyst for change (Tugwell et al., 2006). These studies have provided some evidence on some of the challenges and successes when implementing programmes aimed at addressing inequities (Scott et al., 2008). In sum, a review of the literature thus shows that despite there being a vast body of evidence on inequities in child health, there are still gaps in knowledge that need to be addressed so as to ensure that programmes effectively reach the poor.

A number of the studies that have provided understanding regarding the strategies and interventions that are effective or otherwise in addressing inequities are context specific. This necessitates the need for further studies in other areas and settings to determine the extent to which the intervention can be replicated with similar results. In addition, whereas the majority of studies have provided evidence on the existence of inequities and the possible strategies that are effective or otherwise in reaching the poor with health services, there is a deficiency in research focusing on the implementation of these policies and programmes (Scott et al., 2012). There is also underrepresentation in the studies on the perspectives of the actors in relation to the implementation of these strategies (Gilson et al., 2006).

1.3 Rationale for the Study

The limited evidence on country and context specific interventions to address equity is of major concern as countries strive to reach all segments of their population and achieve universal health coverage. Of further concern, is the inadequate understanding of the factors affecting the implementation of equity-promoting strategies. There clearly is a need for context specific evidence on the factors and challenges faced when implementing programmes that are aimed at effectively addressing the needs of the poor. Such a study not only will contribute to the literature on equity, for it can also provide guidance for governments and programme deliverers on effective implementation so as to reduce inequity in health care.

1.4 Purpose Statement

The purpose of this study is to explore how preventive health care services have been structured for reaching the poor. The specific aim is to understand the extent to which equity issues have been considered in the planning and implementation of a key programme of the Ministry of Health, using as a case study the Community Growth Promotion (CGP) Programme. This programme has been implemented in a number of countries and has been found to be

effective in improving the nutritional status of children (Alderman et al., 2009; Alderman, 2007). The CGP intervention was initially implemented in a few communities in a few districts in Ghana on pilot basis with funding from the United States Agency for International Development (USAID), Glaxo Smithkline's (GSK) social arm and the World Bank (Ghana Health Service; World Health Organization, 2011). In 2007, this strategy received major funding (approximately $13million) from the World Bank, thereby transforming it from a pilot programme to a national programme targeting approximately 300,000 children in 65 districts in eight out of the ten regions of the country (World Bank , 2007). The Ministry of Health, Ghana, through funding from the World Bank, initiated the Nutrition and Malaria Control for Child Survival Project to scale up GCP to all districts in five regions in the country and one district each in three additional regions (The World Bank, 2007). As at December 2012, CGP was being implemented in 77 districts in 6 regions, and more than 600,000 children under two years old in 2500 communities were benefitting from its services (Awittor, 2012). That is, CGP emerged as a priority programme after being initiated at a few pilot sites and then rolled out with large scale implementation around the country. As a priority programme implemented by the Ministry of Health, it is important to ascertain how well aligned this programme is with the pro-poor policy thrust of the Ministry of Health. The study therefore sought to explore the following:

- How is Community Growth Promotion (CGP) structured and delivered to reach the poor?
- What is the perception of health workers and volunteers at all tiers in the health system of health equity issues?
- How do health workers and volunteers at all tiers in the health system integrate equity issues in planning and implementing CGP?
- What factors influence the uptake of CGP and health services among the poor at the community level?

This study is critical considering the high level of priority given to addressing the health of the poor by the Ministry of Health as well as the relatively high prevalence of poverty in Ghana, with 24.2% of the population being considered poor (Ghana Statistical Service, 2014).

1.5 Objectives of Research

The aim of the study is to explore and understand how a preventive health care service - community growth promotion is structured and delivered to reach the poor. The specific objectives are:

- To understand the experience of implementing community growth promotion from the perspectives of the implementing actors at the regional, district and community levels, with specific focus on its delivery to the poor and marginalised.
- To conduct an analysis of equity issues in the community growth promotion programme in Ghana.
- To understand the factors that influence the uptake of interventions among the poor at the community level.

To address the research questions effectively and to achieve the set objectives, a qualitative study was carried out using a case study approach. This enabled in-depth investigation into the structure, delivery and uptake of community growth promotion aimed at reaching the poor. Multiple data collection methods, including documentary analysis, in-depth interviews and focus group discussions, were employed during the study to enhance the depth and breadth of the research. This thesis presents the background and context of the study, the detailed methodology employed, the key findings and conclusions. This initial chapter, which serves as the introductory chapter, has provided an outline the background to equity and poverty issues, explaining the problem of inequity and how health services are not reaching the poor. The chapter has continued with a brief summary of the literature and the key deficiencies that require further investigation in this area. The purpose of the study has been set out as well as its importance in terms of what it adds to the existing body of knowledge. The subsequent chapters of the thesis present a review of the literature, an overview of the methodology, the

key findings and discussion of these, which is followed by the conclusion. The next chapter presents a review of the literature.

2. Literature Review

2.1 Introduction

This chapter presents a review of the literature on child health inequities and provides the context for the conducted study. The review examines, in-depth, the literature on poverty and health with particular focus on child health interventions aimed at reaching poor. As community growth promotion (CGP) is a public health programme, mainly delivering preventive interventions, the review literature search was focused more on these areas. The findings from the search are presented, starting with a broad overview of poverty and health and the resulting inequity. The next section presents the linkages between poverty and child health, showing the prevalence of inequities in child health status and the coverage of key child survival interventions. Having established this linkage between child health and poverty, the section presents further the pathways through which poverty interplays with the health determinants, thereby leading to the negative outcomes, including barriers to health service provision and its utilisation by the poor. The next section reviews strategies that have been utilised to address poverty in health service provision, including increasing financial access and policies within and beyond the health sector aimed at improving equity in access to and utilisation of health services. Subsequently, the strategies and methods that have been deployed to monitor and evaluate interventions to ensure they are meeting the objectives of equity are discussed. The review concludes with a summary of the findings from the literature, the key gaps that need to addressed, thereby justifying the rationale for the study.

2.2 Search Strategy

The literature search was guided by the focus of the study on public health approaches and the Pub Med / Medline MeSH database was used to generate the terms used. Those yielded were reviewed and the appropriate terms selected were as follows:

- Child health services, child survival,
- Poverty / socioeconomic / lower income group / health inequities, reaching the poor.
- Preventive / health

These terms were used to search the Web of Knowledge, as it gives access to a wide range of articles within the Web of Science, Medline, ISI Proceedings and BIOSIS Previews databases. In addition, the databases of the International Journal for Equity in Health, EMBASE and Eldis were utilised. The search was conducted initially in June 2009, reviewed in 2011 and a final updated search was made between July and August 2015. The search yielded several articles and the abstracts were reviewed to select the most relevant. In addition, the references of key articles were reviewed to identify additional articles on the subject area. Whilst the focus was on child health services, some articles that covered adult services were included where they addressed issues of reaching the poor with health services. The search thus yielded a number of articles, reports and documents on the subject area which are reviewed in what follows.

2.3 Findings from the Review

2.3.1 Child Health and Poverty

2.3.1.1 Existence of Inequities in Child Health

There are health inequities prevalent in relation to child health status and service coverage (Zere & McIntyre, 2003; , Fotso, 2006; Fenn et al., 2007; Fernandez et al., 2007; Van de Poel et al., 2007; Gupta & Thakur, 2008; McGillivray et al., 2009). A review of the Demographic Health Survey results from 15 sub-Saharan African countries showed that the children from the

poorest households had the highest risk of undernutrition (Fotso, 2006). These findings confirm the marked inequities in child health and the importance of identifying the determinants in order to address them.

2.3.1.2 Determinants of Child Health Inequities

Wagstaff proposes a conceptual framework for understanding health inequalities. This framework outlines the pathway through which Government policies and actions, the health system and related sectors, as well as household and communities affect health outcomes (Wagstaff, 2002). This gives an indication as to the various points at which socioeconomic, cultural and other factors of disadvantage may act to influence health outcomes, thereby resulting in health inequities. The disparities may be further explained by the socioeconomic distribution of the proximate determinants of child health. Poor children, in contrast to those from wealthier families, are more likely to have inadequate water and sanitation, poor housing conditions, indoor pollution and high exposure to disease vectors (Victora et al., 2003). They are also more likely to suffer from nutrient deficiencies, thus resulting in decreased resistance.

There have been a number of evidence-based interventions that have addressed the proximal determinants of child mortality sector (Jones et al., 2003). These interventions, usually delivered by the health sector, include preventive and treatment regimes, which address the common causes of death in children under-five. The preventive interventions include appropriate infant and young child feeding (breastfeeding, complementary feeding); use of insecticide treated materials; water, sanitation and hygiene; vaccination against such as measles and haemophilus influenza; vitamin A and zinc supplementation; clean delivery; and other maternal and neonatal interventions. The treatment interventions include oral rehydration therapy; antibiotics for pneumonia, neonatal sepsis and dysentery; anti-malarial; new-born resuscitation; and zinc and vitamin A for the treatment of diarrhoea and measles, respectively. The evidence, however, shows that despite their high exposure to these proximate determinants of child health and mortality, the poorest children are least likely to

receive the preventive interventions such as vaccination, immunisation and use of insecticide treated nets (Victora et al., 2003). The low coverage of these preventive and curative interventions further perpetuates the inequities associated with child health.

2.3.1.3 Barriers to health care

The low coverage of child health interventions amongst the poor is also influenced by underlying factors, such as financial costs, socio-cultural factors and health care provision, which serve as barriers to health care and hence, contribute to these inequalities (Wagstaff et al., 2004). The financial costs include the fees for health services provided, which are referred to as out of pocket payments (OOP), the costs of transportation to the health facility as well as the opportunity costs as a result of lost income from not engaging in economic activities. The OOP usually include the levied cost for services, co-payments when insurance does not cover the full cost of services and costs of medicines purchased (Carrin et al., 2008). The OOP have been found to affect the utilisation of health services particularly by the poor (Lagarde & Palmer, 2008). The existence of OOP, in addition to being a barrier to accessing health care by the poor, also leads to them incurring catastrophic health expenditures, thereby perpetuating the cycle of poverty and ill health (Buigut et al., 2015; Leive & Xu, 2008). The evidence thus shows that out of pocket payments and other financial barriers are critical in accessing care. Another barrier to accessing care by the poor is the distance from the facility. The poor tend to live further away than the less poor and this is associated with poorer care-seeking behaviour, lover levels of vaccine coverage and lesser use of mosquito nets for children (Schellenberg et al., 2008). The characteristics of the health care service, such as human and material resources, technical and organisational quality as well as relevance and timeliness of services, similarly influence the extent to which child health services reach the poor (Wagstaff et al., 2004; Wagstaff, 2002). In sum, the evidence indicates that the poor are disadvantaged in accessing health care on account of the numerous barriers faced.

2.3.2 Strategies to address poverty and child health

Addressing health inequities requires strategies to address the major barriers to accessing health care by the poor. There have been varied responses to address such inequities, which Macinko and Starfield group into three main approaches (Macinko & Starfield, 2002):

1. *Increasing or improving the provision of health services to those in greatest need;*
2. *Restructuring health financing mechanisms to aid the disadvantaged;*
3. *Altering broader social and economic structures intended to influence more distal determinants of health inequities.*

The literature on these strategies is reviewed in the ensuing paragraphs.

2.3.2.1 Increasing or improving the provision of health services to those in greatest need

The literature shows there are a number of strategies that have been utilised to improve service provision to those in greatest need with varying degrees of effectiveness. These include the use of community based strategies, integrated delivery of services and targeted services for the poor (Callaghan-Koru et al., 2013; Findley et al., 2006; Grabowsky et al., 2005). These have shown varying impact in reducing health inequities.

<u>Community Based Strategies</u>

Community based strategies have been implemented in a number of settings to increase the uptake of child health interventions amongst the poor and reduce inequities. These include community based health education and behaviour change strategies targeting pregnant women and mothers of infants to improve pregnancy, neonatal and infant outcomes and integration of immunisation promotion in community programmes targeting the minorities (Houweling et al., 2015; Margolis et al., 2001; Callaghan-Koru et al., 2013; Findley et al., 2006; Razzaque et al., 2007).

Different modalities have been utilised to reach women who were pregnant or had neonates or infants with health education messages and services. These include the following:

- Use community based health surveillance assistants to conduct home visits to pregnant women and new-borns during the post-natal period,
- Monthly or fortnightly meetings of women's groups consisting of pregnant women, to identify problems during pregnancy, delivery and the new-born period
- Integration of immunisation promotion activities into ongoing programmes on child care, parenting for marginalised women and children within the community with high levels of poverty.
- Provision of maternal and child health and family planning services initially through home visits and subsequently, through facility based care in a defined area.

The results from these studies showed the effectiveness of the community based strategies in addressing health inequities in various outcome measures. Utilising community-based strategies led to an uptake of health services such as educational sessions, well-child visits and facility deliveries to a similar or greater extent in the lower socioeconomic groups than in the wealthier groups (Houweling et al., 2015; Margolis et al., 2001; Callaghan-Koru et al., 2013). There was also a significantly higher level of improvement of knowledge of the danger signs regarding pregnancy, delivery, and postpartum and facility delivery amongst the poorest quartile, compared to the least poor. Community strategy led to an increased coverage of immunisation in the intervention area from a level significantly lower than the national average to higher than it, thereby reducing the inequity in immunisation coverage (Findley et al., 2006). Razzaque et al., (2007), showed a reduction in inequity in child mortality, whereas the inequity in the overall under-five mortality and neonatal mortality worsened. The results from these studies illustrate the varying health outcomes that can be achieved with different community based interventions.

Beyond confirming the effectiveness of community based interventions in addressing equity, the studies also provided empirical evidence on the factors that led to minimal differences in

the uptake of the intervention across the socioeconomic groups (Houweling et al., 2015, Findley et al., 2006). The motivation by the facilitators encouraged women irrespective of their socioeconomic background to attend the sessions; also the use of simple and interesting discussion tools and methods helped the women to understand and kept them interested in the discussion. Another factor influencing the uptake was the closeness of the services to their homes and the suitable meeting times thus enabling them to attend the sessions without difficulty. Other success factors indicated were community ownership; building on existing community organisational strengths and structures; and shifting communication of immunisation messages from the health providers to the communities. The literature thus does provide evidence on the critical success factors for consideration with community based programmes.

In line with the evidence from these studies, Soeung et al. (2013), based on the findings from a national review of an immunisation programme, have proposed a shift in strategy from reaching every district to reaching every community in order to address inequity. They propose a five-phase process, which include the refocus of planning shifting from the district to the community and facility level, establishing community monitoring systems, developing communication strategies addressing the needs of the community, service delivery based on the need and mobilisation of resources to finance targeted interventions (Soeung et al., 2013).

The evidence from the literature does indicate that community based strategies can be effective in addressing child health inequities across socioeconomic groups. Despite the fact that a number of studies were carried out in a specific settings and hence, the findings not being generalizable, the success factors identified are principles that could be adapted and applied in a different context. Whilst a number of the extant studies have been observational, the availability of evidence from a multi-site randomised trial does provide more unbiased findings that can be applied in various settings. In addition to the effectiveness of the interventions in addressing equity, the evidence also provides some guidance on the key factors that need to be taken into consideration in the design and implementation of community based

interventions aimed at addressing inequity. Despite the literature seeming to suggest that community based interventions are effective in addressing equity, there are some exceptions. The observed effectiveness of the community-based interventions in reducing the health inequities identified was applicable mainly to child health and some maternal health interventions. A community-based maternity programme showed an expansion in services, but not to all who needed them (Anwar et al., 2005). This implies that whilst community based interventions might be effective in addressing inequity for some types of interventions, they may not applicable to all forms and settings. There is need for additional studies in specific settings to identify what works best in reaching the poor.

Integration of Services (vaccination with ITN)

In addition to community based interventions, another strategy for increasing the services to those in greatest need is the integrated delivery of services. Studies have shown that integrating the distribution of insecticide treated nets (ITNs) with a measles vaccination campaign led to an improvement in equity in the ownership of treated nets and vaccination coverage (Grabowsky et al., 2005; Goodson et al., 2012). The studies, conducted in three countries in sub-Saharan Africa, showed an increase in the equity ratio post – campaign for ITN ownership and measles vaccination. The evidence from these studies, thus, shows that integrated delivery of services might lead to improved coverage of the interventions amongst the poor and hence, contribute to addressing health inequities.

Improving Service Delivery

Evidence from country case studies on reaching the poor with health, nutrition and population services, shows varying outcomes in their effectiveness in reaching the poor (Gwatkin et al., 2005). The studies covered a range of interventions in relation to malaria, reproductive health, HIV, and child health services (Grabowsky et al., 2005; Montagu et al., 2005; Thiede et al., 2005; Anwar et al., 2005; Schwartz & Bhushan, 2005; Ranson et al., 2005;, Peters et al., 2005; Malhotra et al., 2005;, Gasparini & Panadeiros, 2005; Barros et al., 2005; Valdivia, 2005). Being case-studies, these were detailed and intensive and enabled the interventions to be

studied in their context. However, there were no controls and thus, the outcomes were subject to various biases. Six of the programmes clearly showed better outcomes amongst the poor (Grabowsky et al., 2005; Thiede et al., 2005; Schwartz & Bhushan, 2005; Malhotra et al., 2005; Gasparini & Panadeiros, 2005; Valdivia, 2005), whereas two others showed mixed results (Ranson et al., 2005; Barros et al., 2005). The successful programmes were maternal and child health and child feeding programmes, primary health services, distribution of insecticide treated bed nets, and participatory and educational approaches. The programmes with mixed results included the immunization and ante-natal care, primary health services and reproductive health service and detection of tuberculosis with women's education. The evidence thus implied there was no universal strategy for addressing the needs of the poor, as different approaches were successful depending on the context or setting in which they were applied. A more recent systematic review by Yuan et al. (2014), showed that five kinds of interventions - immunization campaigns, nutrition supplement programmes, health care improvement interventions, demand side interventions, and mixed interventions were effective in addressing inequalities in health care. This review deduced that interventions that were effective were those that provided basic health care services, focused on outreach or close to client services, or provided financial and knowledge support to increase demand. The review however concluded the need for additional evidence on contextual information and implementation processes of these interventions. There is the need for further studies in country specific settings to determine what strategies work best in a particular context. In sum, the literature shows that there have been a number of strategies that have been utilised to address health inequities, with varying degrees of success. Community based strategies have been quite effective in addressing equity, however, the outcome measures tracked have been at the level of output and outcome indicators, with minimum focus on the impact indicators.

2.3.2.2 Restructuring health financing mechanisms to aid the disadvantaged: Addressing financial barriers

In addition to the strategies aimed at improving the provision of health services to those in greatest need, another key area for addressing inequity is the restructuring of health financing mechanisms. This requires the removal of OOP mechanisms and the replacement of these with a pre-payment mechanism that ensures access to care for all, i.e. universal coverage (Carrin et al., 2008). There have been various strategies utilised to decrease financial barriers to accessing health care with varying results in terms of utilisation of health services by the poor (Axelson et al., 2009; Lambert-Evans et al., 2009; Coronini-Cronberg et al., 2007). These include specific health funds for the poor (Axelson et al., 2009; Jacobs & Price, 2006), co-payment schemes for the population with exemptions for the poor (Lambert-Evans et al., 2009; Coronini-Cronberg et al., 2007); and health insurance schemes for the poor (Frenk et al., 2009) as well as the entire population (Agyepong & Adjei, 2008). Whilst these interventions were successful in decreasing the OOP expenditure and increasing utilisation of the services amongst the beneficiaries, their effect on addressing inequity was dependent on the appropriate identification of the poor as beneficiaries. For the health equity funds, the experience from Cambodia indicated that when using community approaches, the poor were rightly identified and thus, the beneficiaries of the programme were found to be significantly poorer that the non-beneficiaries (Jacobs & Price, 2006). In contrast to this finding, the evaluation of the co-payment schemes indicated that the majority of the poor who were to be exempted from payments were not identified as beneficiaries (Lambert-Evans et al., 2009; Coronini-Cronberg et al., 2007). The literature thus shows that even though health financing mechanisms to address the poor may be effective in reducing costs and increasing utilisation, unless they are targeted and benefit from the services, these will not address health inequity.

2.3.2.3 Altering broader social and economic structures intended to influence more distal determinants of health inequities.

In addition to improving the provision of health services to those in greatest need and restructuring health financing mechanisms to aid the disadvantaged, there is literature on other strategies that could address health inequities, which have been focused on the more distal determinants. These include social policy interventions such, as the conditional cash transfers, expansion of sanitation and services as well as strengthening of management approaches, such as the Global Equity Gauge Alliance (GEGA) (Scott et al., 2008). The literature on these interventions is analysed in the ensuing paragraphs.

Conditional cash transfer (CCT) is a social policy intervention that transfers money to poor households on condition that they make investments in the human capital of their children (Fiszbein et al., 2009). These investments are in health, nutrition and education and the conditions specified include the utilisation of health services for health education by mothers, growth monitoring of children, vaccination and perinatal care; and enrolment of children in schools. A number of countries, particularly the middle income countries in Latin America, have utilised this mechanism as means of increasing the utilisation of health services and improving health outcomes among the poor (Barham & Maluccio, 2009; Fernald et al., 2009; Morris et al., 2004). A systematic review by (Owusu-Addo & Cross, 2014) showed some evidence of the effectiveness of CCT in improving health service utilisation, immunisation coverage and nutrition amongst the children of the targeted families. The review also revealed a decline in the prevalence of diseases amongst the children of families receiving the intervention. A further impact of the CCT was the reduction in infant mortality rates, particularly amongst populations where mortality was high prior to the intervention (Shei, 2013). The evidence from several countries thus indicates that the implementation of a CCT strategy does contribute to addressing child health.

The CCT programmes have also led to reduction in childhood poverty and also contributed to addressing inequity (Owusu-Addo & Cross, 2014; Barham & Maluccio, 2009; Soares et al., 2006). The effects of the benefits in child health were higher for those who had lower coverage and were traditionally harder to reach - who lived further from the facility and/or were less educated (Barham & Maluccio, 2009). These tend to be the poorer segments of the population. The intervention, by contributing to equalising the coverage, was improving equity. Also, when the programme is well targeted, with the poorest receiving most of the transfer and minimum uptake amongst the rich, it is associated with a decrease in the incidence of the intensity of poverty and inequality (Soares et al., 2006). Other interventions such as improving sanitation, when targeted at the poor, also have the potential to reduce health inequalities and improve child health outcomes (Acharya et al., 2013). The evidence from the literature thus indicates that CCT and other interventions outside the health sector have the potential to contribute to the reduction of poverty and address child health inequities.

Despite the success of CCT in reducing poverty and improving child health outcomes (Owusu-Addo & Cross, 2014), a qualitative enquiry has brought to the fore some of the limitations in its effectiveness in enhancing the utilisation of health services (Adato et al., 2011). This multi-country study, showed how the interplay of socio-cultural factors on the pathways leading to the increased uptake of interventions as well as the structure of the health system affected the uptake of services. Despite the CCT being found to be a very powerful incentive, where there were gaps in the health service delivery, it did not result in the expected positive outcomes. Also, some of the health service practices were considered to be against certain socio-cultural and gender-related beliefs and norms and hence, this affected the use of the health services even when incentives were provided. Thirdly, there was a negative experience associated with poverty within the health care system in some areas, where the poor felt a "sense of social exclusion and discrimination" (Adato et al., 2011, p. 1928). These studies show that even though there is evidence of the positive impact of CCT in reducing poverty and inequalities, there is the need to improve the availability and acceptability of the health services in order to derive the maximum benefits from the intervention. Consequently, it is crucial that further

studies are carried out to understand the local context in order to benefit from the application of CCT.

2.3.3 Monitoring and evaluating interventions that reach the poor

Whilst the literature shows evidence of the effectiveness of a number of interventions in addressing equity, these are by no means exhaustive, as the different countries settings, availability of resources will determine what works best for the particular area. As countries consider the different strategy and programme options for addressing inequity, careful monitoring and evaluation of programme inputs, processes, outcomes and impact are important for ensuring that they reach the poor and result in a reduction of inequities. A number of quantitative, qualitative and mixed method approaches have been used in evaluating the effectiveness of interventions in reaching the poor, as well as understanding the factors that influence them when trying to reach the poor.

The quantitative approaches that have been utilised are techniques, such as benefit-incidence analysis to estimate the distribution of health outputs from, for instance, home visits, clinic visits or immunisations amongst the different socioeconomic groups and gradients to calculate inequality using concentration curves (Wagstaff & Waters, 2005). These methods require a measure of the living standards of the population and income, expenditure and consumption patterns or a wealth proxy can be used. The use of asset indices is a good such proxy that can be used when other measures are not available (Houweling et al., 2007). Incidence-benefit analysis and concentrative curves have been applied in a number of cross-sectional, time-series and experimental studies to determine the distribution of programme benefits amongst the poor (Gwatkin et al., 2005). The use of concentration indices has also been applied in the analysis of secondary data to determine the effectiveness of programmes in reaching the poor (Mathanga & Bowie, 2007). These methodologies, whilst useful in determining the effectiveness of the programmes, do not provide any reasons for success or otherwise in this quest and hence, the need for more in-depth analysis.

The programme analysis method provides an example of an in-depth approach that can be used to measure inequality and the factors underlying it. This approach was deployed to assess how equitable the HIV and tuberculosis programmes were in Malawi (Simwaka et al., 2007; Makwiza, et al., 2009). The researchers used multiple sources of data – review of the programme reports, documents and epidemiological data, literature review, in-depth interviews and focus group discussions. The analysis of the tuberculosis study involved utilising an existing framework on the tuberculosis pathway to care as well as gender and poverty analysis. The multiple sources of data enhanced the breadth and scope of the information generated. The results from the study showed how health service and patient related barriers affected the uptake of the tuberculosis interventions amongst the poor, as well as the impact of the disease and care-seeking on the patients and their families (Simwaka et al., 2007). These studies demonstrate the importance of in-depth studies using a wide range of approaches, including quantitative, qualitative and mixed approaches so as to understand the nature and magnitude of the challenges in relation to accessing health care by the poor, thereby allowing for better structured programmes aimed at meeting their needs.

The evidence from such studies on equity have been utilised to influence policy and action (Scott et al., 2008). The Global Equity Gauge Alliance (GEGA) in Cape Town illustrated how research could lead to policy and action through the steps of assessment and monitoring, advocacy and community empowerment (Scott et al., 2008). There are, in addition to the GEGA, other tools to draw attention to health inequities and help to focus resources in addressing them (Tugwell et al., 2006). These include databases of systematic reviews on the effects of various interventions in relation to addressing inequities, such as the Cochrane and Campbell Collaborations, the use of health coaches in helping disadvantaged groups in decision-making based on evidence, the use of the community information and epidemiology technologies (CIET) techniques in evidence-based planning, and the Needs-Based Health Assessment Toolkit (Tugwell et al., 2006). Whilst such tools have been found to be useful in evidence based planning, they each have their strengths and limitations, with country, local

context and the participation of all stakeholders being critical to adapting and utilising them effectively.

The application of the GEGA tool in the Cape Town Metropole demonstrates the importance of local context and the participation of all key stakeholders in the process of moving from research to policy and on to action (Scott et al., 2008). When applying the equity tools by the health managers, it was found that whereas there was agreement on the high rates of inequity and the need for action amongst them at the three tiers of governance (national, provincial and district levels), when it came to implementing the actions, district level managers faced major constraints in the process. The approach, whilst being successful in placing equity issues on the agenda, also brought to the fore challenges in terms of implementation. Despite the policy goal of addressing equity being generally accepted by the stakeholders, there was resistance to some of the specific strategies adopted for achieving the goal (Scott et al., 2012). This highlights the need for context specific research in understanding the process of change and implications (Scott et al., 2012). Despite these challenges of implementation in the process of addressing equity issues, there has been limited attention paid to this area (Scott et al., 2012). This finding raises the importance of understanding the processes and perspectives of stakeholders for successful implementation of policies and programmes aimed at addressing health inequities.

Gilson et al. (2006) propose the application of policy analysis in addressing the issues and challenges faced when implementing programmes to address the poor and marginalised (Gilson et al., 2006). They suggest the application of the analysis at the national and global level in policy development as well as the lower levels, so as to comprehend the various stakeholders and factors affecting implementation. Walt et al. (2008) outline steps to guide researchers in using the policy analysis approach (Walt et al., 2008). They provide an overview of the various theories and frameworks used in the public policy process, the methodology in designing health policy studies and the positionality of the researcher in the policy analysis. Some of the frameworks include a stages heuristic approach, which divides the public policy process into

four stages - agenda setting, formulation, implementation and evaluation along with a policy triangle, which focuses on policy content, the context, actors and processes. The application of this approach to programmes for addressing poverty will contribute to the literature on inequity.

2.4 Summary and Conclusion

The review of the literature indicates clearly the existence of health inequities in the health status and coverage of health interventions, for those in the lower socioeconomic groups. There is evidence of inequities in child health status and service coverage as well as how the socioeconomic distribution of the proximate and distal determinants of health which continue to act to perpetuate these inequities. The evidence thus shows that despite their high exposure to the determinants of ill health and mortality, the poorest children, on account of the barriers they face in accessing health care, are least likely to receive the needed health interventions.

There are a number of strategies that have been implemented with varying degrees of effectiveness in addressing the barriers to health care faced by the poor. These include increasing the provision of health services to those in greatest need; restructuring health financing mechanisms to aid the disadvantaged; and altering broader social and economic structures with the purpose of influencing more distal determinants of health inequities. The key approaches that have been utilised to increase the provision of services to those in need are community based strategies and programmes, integration of services and improving service delivery. Community based strategies, whilst being effective in addressing inequity, have focused on outcome measures mainly at the level of output and outcome indicators, with minimum focus on the impact indicators. There is also a significant amount of literature on the financial health mechanisms that have been utilised by countries to help the poor. These include health insurance schemes, health funds for the poor and co-payment. Whilst these have improved financial access and utilisation of services by the beneficiaries, a number of them have not adequately targeted the poor who need the interventions. The literature also reveals

that CCT as a key strategy that has been effective in addressing child poverty and health inequities. However, this strategy must be deployed with restructuring of the health services to meet the increased demand and be acceptable to the population. The extant literature shows that there have been a number of strategies that have been utilised to address health inequities with varying degrees of success. There is the need for further monitoring and evaluation of interventions in country specific settings to determine what strategies work best in a particular context.

The prior research highlights several methodological approaches in determining the effectiveness of interventions in reaching the poor. Quantitative, qualitative and mixed method approaches have been used in evaluating the effectiveness of interventions in doing so, as well as understanding the factors that influence these interventions. A number of the studies have focused on the measurement of the distribution of various health outputs amongst the poor as well as the reviewing and analysis of policies and programmes aimed at improving the health of the poor. Whilst there is evidence on constraints in implementing equity-promoting policies and programmes, there has been relatively limited work undertaken to understand the processes and challenges when implementing the policies and programmes aimed at improving their health. There is, therefore, a need for further research that can shed light on the processes and challenges faced when implementing programmes in this context. This evidence is critical for addressing health inequity and achieving the global goal of universal health coverage. Health policy analysis represents a validated approach that can be applied for understanding the process and challenges in implementing programmes. This qualitative analysis will enable comprehension of the perspectives of various stakeholders and the factors affecting implementation. This approach is thus to be applied to the aforementioned community based programme - Community Growth Promotion - to explore and gain understanding of how it is structured to meet the health care needs of the poor and marginalised. The next chapter expounds the methodology, elaborating in detail how the current study was carried out to address this aim.

3. Research Methodology

3.1 Introduction

This chapter gives a detailed presentation of the research methodology used for the study. It begins with a brief summary of the philosophical assumptions of qualitative research and the role of the researcher, thereby establishing the context within which this study was conducted. The chapter continues with description of the qualitative design, followed by the data collection and data analysis procedures, the validity checks and finally, there is consideration of the ethics and confidentiality issues. This chapter, thus, provides orientation on the methods underpinning the research and helps the reader to understand the context.

3.2 Overview of Qualitative research

3.2.1 Objectives of Qualitative Research

Qualitative research methods were used for the study as this provides explanation and helps in understanding of phenomena, by emphasising "words rather than quantification in the collection and analysis of data" (Bryman, 2008, p. 366; Green & Thorogood, 2002). This research method is increasingly being applied in health service delivery, policy and management (Green & Thorogood, 2002). Qualitative health research provides the opportunity for researchers to explore aspects of public health that are not easily explained by quantitative research. Qualitative research has been used to investigate lay people's perceptions of health inequalities (Bolan, 2005). Ritchie and Spencer (1994) propose a number of objectives of this type of research, as outlined below (Ritchie & Spencer, 1994):

- Defining concepts: understanding internal structures;
- Mapping the range, nature and dynamics of, theories or strategies;
- Finding associations: between experiences and attitudes, between attitudes and behaviours, between circumstances and motivations, etc.;

- Seeking explanations: explicit or implicit;
- Creating typologies: categorising different types of attitudes, behaviours, motivations, etc.

This study, by exploring and seeking to understand processes and structures, was in line with the objectives of "mapping the range, nature and dynamics of phenomena, and seeking explanations".

3.2.2 Philosophical Epistemology

Qualitative research is underpinned by the ontological and epistemological positions adopted by the researcher. There are various philosophical worldviews or paradigms that a researcher adopts and this influences the ontological position, the epistemology and the methods of the research, respectively (Guba & Lincoln, 1994; Cresswell, 2014). The common paradigms are positivism, post-positivism, critical theory and related ideological positions (which is also described as transformative), constructivism and pragmatism (Guba & Lincoln, 1994; Cresswell, 2014). The positivist worldview is closely linked with the post positivist worldview and with this position, also known as empirical science; it is believed that knowledge is developed through the observation of an external reality that exists. This worldview is commonly associated with quantitative approaches. The transformative worldview encompasses the views and assumptions of critical theorists, participation action researchers, Marxists, feminists, minorities and marginalised groups. Under this worldview, it is believed that research should have a political agenda and should be aimed at changing the situation of the participants (Cresswell, 2014). This paradigm is associated with a transactional and subjective epistemology (Guba & Lincoln, 1994). The pragmatic worldview focuses on the research problems and is not committed to any philosophical approaches, but rather, what works best to address the identified problems (Cresswell, 2014). This approach is commonly associated with mixed methods research. However, the positivist worldview was not a key underpinning factor in this study.

In contrast to the positivist worldview, constructivism has a relativist ontological position, under which the existence of multiple realities as constructed by different persons is believed in (Guba & Lincoln, 1994). This paradigm, associated with an interpretivist epistemological position, seeks to understand the social world through the interpretation of participants. Within this context, knowledge is relative and is created through interactions between the researcher and the respondents. The constructionist ontological position is that "social properties are outcomes of the construction between individuals rather than phenomena 'out there' and separate from those involved in its construction." (Bryman, 2008, p. 366). The constructionist worldview is the common approach to qualitative research (Cresswell, 2014) and has guided my approach to this study. Adopting the constructivism paradigm is critical to understanding the perspectives of the stakeholders who are crucial in addressing issues of equity.

3.2.3 Theory and research

Another factor that needs to be considered in qualitative research is the roles of theories in guiding the methods. Theories can be used deductively to guide the research question, research design and analysis (Kelly, 2010). Creswell (2014) describes four ways in which theories are used in qualitative research: firstly it can be used to explain behaviour and attitudes studied and in this context may provide variables, constructs and hypothesis for the study. Secondly, it may be used as a "theoretical lens or perspective" (p. 64) for transformational research. Thirdly, theories can be generated through the research in an inductive manner by building themes from the data, which are then developed into theories or generalisations. Fourthly, there might not be any theories explicitly in the research, as is the case with phenomenology. In this study, I applied a combination of deductive and inductive approaches in the use of theory. There were a number of theories that I drew upon from the literature to guide the research design and the analysis of the findings. In my role as researcher, utilising the framework analysis approach, I analysed the data and generated from these, various concepts and themes, which I merged with the theories from the literature. Thus, there was a balance of the deductive and inductive methods applied in the study.

Green and Thorogood (2002) identify three levels of theories - macro-theories, middle-range theories, and theories of knowledge - as influencing research (Green & Thorogood, 2002). Social theories upon which research can be based include: Conflict, Structural fundamentalism, symbolic interactionism, sociology of knowledge, Feminist theory (Willis, et al., 2007). For this study, health policy analysis theories and frameworks were drawn upon, including the stages heuristic, policy triangle frameworks as well as the multiple streams and implementation theories (Walt et al., 2008), during various stages in the research process. The stages heuristic framework guided me in organising the inquiry around the different stages in the policy process and this was applied in the structure of the interview guides, as well as during the analysis. The policy triangle model (Walt & Gilson, 1994) guided the focus of the research, reviewing the content, context and the process in health policy, mainly from the perspectives of the actors.

3.3 The Role of the Researcher

In qualitative research, due to the interpretative nature, the researcher needs to identify clearly his or her biases, personal values and background that may influence the interpretation of the outcomes (Cresswell, 2014). My perspectives of the community growth promotion programme have been influenced by my work. As the National Professional Officer – Child and Adolescent Health and Nutrition, World Health Organization, Ghana Country Office from 2001 to 2013, I was involved in the technical development of the programme and supervision in the pilot phase. I was also involved in the consultation and planning process leading to the scaling up of the programme beyond the four pilot districts to several other districts. In two in Eastern Region, I was directly involved in mobilising resources for the programme and made a number of follow up visits. I, therefore, have a reasonable understanding of how the programme is expected to be organized and implemented. In my role, I was also involved in the National Health Policy dialogue and through this gained some perspectives of the national priorities, in particular, the emphasis on equity. My involvement in the community growth promotion programme and the National Health Policy dialogue increased my awareness and understanding of the issues raised in this study.

My in-depth involvement and knowledge of the issues was critical in engaging and interviewing the senior level policy makers and programme managers at the national and regional levels. The interviewing of this category of senior level and expert participants, referred to as elite in the literature is associated with some complexities and hence the position of the researcher is crucial (Wicker & Connelly, 2014; Harvey, 2011). Some of the complexities relate to the availability of these elites, the power dynamics relative to the researcher and the political nature of the interviews. Being considered an insider and a peer, was helpful in negotiating access to these senior level participants, as I was well known to them and respected professionally by a number of them. Due to my position, I was not considered as a mere student, but a professional and hence there was a balance in the power dynamics between these elite interviewees and myself as the researcher the interviewing process. Thirdly my in-depth knowledge of the issues being discussed enabled me to understand the contextual issues, probe further and refocus the discussion to keep it on track and address the topic. I consider my background and position served as an advantage in engaging and interviewing the senior level participants.

Whilst my prior knowledge of the programme and the context increased my understanding of the issues, it could have also had the potential of making me biased towards some aspects of the study. I tried to minimise these biases by being very detailed and transparent in the research methodology. In addition, the engagement of independent data collectors, transcribers and someone to code also helped to minimise any potential bias in the research process.

3.4 Research Design

A case study design was utilised for the conduct of the research, with community growth promotion as the case (Lewis, 2003; Walt et al., 2008). The case study research design is commonly used in health policy analysis (Walt et al., 2008) This design was deemed appropriate for the study as it sought to address the question of how the community growth promotion programme is structured within its "real life context" (Yin, 2003, p. 13), and thus, it facilitated

the in-depth investigation of the strategy. This case study was guided by theoretical frameworks in terms of the design and analysis (Yin, 2003) and these included the health policy analysis and related frameworks and implementation theories (Walt et al., 2008). These are discussed in more detail in the ensuing paragraph. As is the practice in case studies, this research involved using multiple methods and sources for data collection (Cresswell, 2014; Yin, 2003; Lewis, 2003). Specifically, there was the use of documentary analysis, in-depth interviews and focus group discussions so as to enhance the depth of knowledge obtained.

Theoretical Framework

As has been indicated in the prior text, for the study, a number of frameworks and theories of public policy process were drawn upon (Walt et al., 2008). The stages heuristic divides the public policy into four stages - agenda setting, formulation, implementation and evaluation -, which were used to guide the design and analysis of the study. That is, the exploration of the CGP programme was carried out according to the four stages indicated. In addition to the stages heuristic, the policy triangle framework, which focuses on policy content, the context, actors and processes (Walt & Gilson, 1994) was also employed as a guide to structure the overall analysis. In the more detailed analysis, Buse's Policy Influencing framework was applied for the analysis of the actors (Buse, 2008); multiple-streams theory was engaged with to understand the agenda setting stage, which led to the emergence of CGP as a priority programme; and the top-down implementation theory was deployed for assessing implementation the CGP. Beyond the agenda setting, the next stages in the policy process, formulation, implementation and evaluation were analysed through utilisation of the implementation theories (Walt et al., 2008; Sabatier, 1986). These theories are discussed in more detail in the empirical chapters of this thesis. Other frameworks that were considered for the data collection and analysis include the priority setting and healthcare decision-making criteria frameworks, such as that proposed by Sibbald et al (2009). This framework was used to explore the processes underlying the priority setting and decision-making criteria at the national, regional, district and community levels within the health sector in planning and

implementing community growth promotion. The detailed concepts of the theories are discussed in the empirical chapters.

3.4 Data Collection Procedures

3.4.1 Research Setting

This study focuses on the case of Ghana, a developing country in West Africa, implementing community growth promotion strategy. It was conducted within the Ministry of Health and the Ghana Health Service. The overall Ministry of Health is the sector of Government with the mandate to improve the health of the people of the country. This sector is split into the Ministry of Health as the civil service arm responsible for overall sectoral policy direction, coordination, monitoring and evaluation, and a number of agencies for delivery of services. The Ghana Health Service is an agency of the Ministry, being responsible for the provision of public health and clinical services (Koduah, et al., 2015). The organisation of programmes and services within the Ghana Health Service is at national, regional, district, sub-district and community levels. The implementation of the sector-wide approach provides the platform for the Ministry of Health and its agencies, together with other international donors, to contribute to the programme of work which sets the national priorities for the sector.

The study was conducted across all tiers of the health system - national, regional, and district and community levels. At the National level, both the Ministry of Health and the Ghana Health Service were engaged. At regional level and below, data collection was undertaken within the setting of the Ghana Health Service in the Central Region, one of the implementing regions, which has been one of the poor regions in the southern part of Ghana. The Central is located is located along the southern border of the country along the coast. Its other boundaries are the Ashanti and Eastern regions to the north, Western region to the west and Greater Accra region to the east. The region is made up of a total of 20 districts, consisting of one metropolis, six municipalities and 13 districts. Approximately 66% of the population is employed, with agriculture, fishing and farming amongst the main economic activities that engages about 42%

of those employed (Ghana Statistical Service, 2013). In 1998/99, the Central Region was the poorest region in the southern part of the country, with the incidence of poverty of 48% (Ghana Statistical Service, 2007). By 2012 /2013, this figure was down to approximately 20%, with were variations in the poverty rates in the different districts (Ghana Statistical Service, 2014). Although the headcount of poverty has decreased, the region still has a relatively high proportion of poor housing and sanitation facilities, with 17% and 15% of the population having to bathing or toilet facilities respectively (Ghana Statistical Service, 2013). Two districts - Gomoa East and Mfanstiman - were selected in consultation with the Regional Health Management Team. The districts were selected based on the implementation of Community Growth promotion, which was ongoing at the time of the discussions and the field visit. The poverty incidence in Gomoa East is below, whereas that in Mfanstiman district is above the regional average, with urban/rural distribution of approximately 50% (Ghana Statistical Service, 2013).

3.4.2 Sampling

Purposeful or purposive sampling was carried out to obtain participants who were relevant to the research question being studied (Patton, 1990; Carter et al., 2009). This ensured the selection of "information-rich" or "special" cases, which could provide a lot of insight and understanding of the issue being studied (Patton, 1990; Carter et al., 2009). Patton identifies several strategies for the selection of such "information-rich" cases (Patton, 1990). These include extreme-deviant case sampling, intensity sampling, maximum variation sampling, homogenous sampling, typical case sampling, stratified purposeful sampling, critical case sampling, snowball or chain sampling, criterion sampling, theory based or operational construct sampling, confirming or disconfirming cases, random purposeful sampling, convenience sampling, amongst others. The choice of the sampling strategy is dependent on what the researcher seeks to study, the research questions as well as the resources available. For my study, I used stratified purposeful sampling. This type of sampling helps to illustrate the characteristics of the different sub-groups of interest. The different levels of the health system

in Ghana – national, regional, and district, sub-district and community levels, all have an input in determining how community growth promotion is structured. For this research, I stratified the health system into national, regional, district and community levels and sampled health workers from each of these. This enabled me elucidate the perspectives of health workers at different levels of the health system in addressing equity issues.

At the community level, I applied homogenous sampling, which facilitates the collection of in-depth information from a specific sub-group of people and group interviewing (Patton, 1990). The sub-group was caregivers (women) with children under the age of five from within the community, who participated in the focus group discussions. The advantage of this sampling process is the enabling of people of similar gender, background and experience to share their perspective about a common phenomenon affecting them. Thus, being a homogenous group, the caregivers were more readily able to share their perspectives in the group discussion. Also at the community level, the snowballing sampling technique was applied, whereby the community leaders served as key informants to identify these caregivers. These approaches were utilised to obtain the groups of caregivers who participated in the focus group discussion.

3.4.3 Sample Size

In qualitative research there are no clear cut guidelines on the ideal sample size. Some propose that this is determined during data collection, where additional sampled persons are included so long as new information is generated. Patton, however, proposes that some predetermination of the sample is required for practical purposes during the study design stage, which can be modified during the data collection phase as the need arises (Patton, 1990). This method proposed by Patton was my preferred approach for my study, and as such the pre-determined sample size for the study was based mainly on practical considerations. The predetermined sample size for each level was as follows:

- Four policy makers at the national level – working at the Ministry of Health and the Ghana Health Service (4)
- Eight health service managers at the national, regional, district and sub-district levels (8)

- Four frontline health providers and community volunteers (8)
- Four community leaders (4)
- At least 20 caregivers of children under-five in two focus group discussions.

3.4.4 Recruitment strategy:

Letters were sent via email to the potential participants purposively selected at the national and regional levels two weeks prior to the proposed interview dates. The participants were selected based on their role. At the National level, senior level officers working in the Policy, Planning, Monitoring and Evaluation Divisions of the Ministry of Health and the Ghana Health Service were identified based on their role in the policy process. Programme managers at national level were identified from the Nutrition sub-division that had direct oversight responsibility for CGP. At the regional level, the participants were identified from the Regional Management team – the Regional Nutrition Officer who was in charge of the programme at that level, as well as the Regional Director with overall responsibility of health services in the Region. Those identified were sent letters that sought their willingness and availability to participate in the study, with the information sheet and consent form being enclosed. The letters are included in the Appendix 1 of this thesis.

At the district and sub-district, the participants were identified based on their role in programme management at their respective levels. Thus district directors, district officers in charge of the public health or maternal and child health programmes and sub-districts heads were identified as participants. The recruitment at this level was made through phone calls. I paid a visit to the leadership of the respective districts and informed them about the study and then requested their permission to interview staff in the selected communities. Once permission had been granted, the team of research assistants and I contacted the staff in the respective positions to seek their willingness and availability to participate in the study.

The community health providers (community health nurses) were identified based on their role in service delivery, being the frontline providers at the community level. They were recruited by the research assistants at their duty posts on the day of the interviews. The community

volunteers supported the recruitment of community leaders and caregivers within the communities. Once their willingness was ascertained, the interviews and focus group discussions were conducted at a convenient time and place for the participants. The participants successfully recruited were:

- Three policy makers at the national level: One working at the Ministry of Health and the other two working for the Ghana Health Service.
- Two health service managers at the national level in Nutrition Programme Management
- One Regional Nutrition Officer
- Four district level health service managers
- Two sub-district level health service managers
- Four frontline community health providers
- Four community volunteers
- Four community leaders
- Four focus group discussions with 6-10 caregivers of children under-five in each group.

3.4.5 Types of Data collected

There are two broad approaches to collecting qualitative data (Ritchie, 2003). There are those that focus on naturally occurring data, where phenomena are studied in their natural settings and those that generate data through the actual research process (Ritchie, 2003). Naturally occurring data are appropriate when studying behaviours or practices in their actual context. The main data collection methods associated with this approach are participant observation, observation, documentary analysis, discourse analysis and conversation analysis (Ritchie, 2003). In ethnography or participant observation, the researcher becomes a part of the social phenomenon being studied; watching, listening and asking questions to gain understanding (Bryman, 2008; Ritchie, 2003). This data collection method enables the researcher to see things from the perspective of those being studied, and makes her or him sensitive to the contextual issues. The extended period of engagement may provide the opportunity for researcher to unearth issues critical to the phenomenon being studied that have not been thought about

(Bryman, 2008). This method usually requires a long period of engagement between the researcher and those researched and therefore, could not be applied in this study.

The study was, therefore, focused more on generating data through the research process. Generated data are helpful in understanding the perspectives of people and their interpretation of their circumstances. The data collection methods available include biographical methods, individual, paired or triad interviews and focus group discussions (Ritchie, 2003). The choice of the data collection method depends on the aims of the study and the research questions. For this research, the main type of data collected was generated data from interviews as the focus was to understand the perspectives of the participants. The generated data were, however, supplemented by documentary analysis. A combination of data collection methods was utilised in this study, which is typical for case studies, as it enables triangulation from the different sources (Yin, 2003).

Documentary Analysis

Documentary analysis is the study of documents to comprehend their content or provide in-depth understanding of an issue (Ritchie, 2003). The analysis of documents is engaged with in most case studies, as it can be used to corroborate evidence from other sources, obtain specific details that can be corroborated, and also to make inferences (Yin, 2003). The documentary analysis conducted within this study was carried out to corroborate evidence, obtain details as well as make inferences. Documents that can be studied include administrative and procedural documents, such as reports, minutes of meetings, letters, memos and other communication, media reports as well as protocols, proposals and reports documents from other studies (Yin, 2003; Ritchie, 2003). In this study the community growth promotion proposal, programme along with technical documents and reports were analysed. These were complemented by other national policy and programme documents relating to the pro-poor agenda and equity issues. The documents were obtained mainly through direct requests to key stakeholders and internet research (Yin, 2003). A number of relevant documents were analysed to obtain information that complemented the primary data obtained.

Qualitative In-depth Interviews

Qualitative interviewing is applicable when investigating issues that cannot be studied through observation. With qualitative interviewing, the underlying philosophy is not of a fixed external reality, but one that is interpreted from the perspective of the interviewee (Bryman, 2008). The qualitative interview is less intrusive than participant observation and can be used to explore a wide range of issues (Bryman, 2008); it also helps in the reconstruction of events. Qualitative interviewing was the approach adopted for the study as it enabled me explore and understand the perspectives of the key actors involved in community growth promotion. Using this method also allowed me to study more participants in detail than would have been possible through observation only.

The qualitative interviewing process is less structured, flexible, and more interested in the participant's point of view. Interviewers may deviate from the interviewing schedule and allow the participants to express their thoughts and feelings about the phenomenon being studied. The two main types of qualitative interviews are the unstructured interview and the semi-structured interview. In an unstructured interview, the researcher uses very few points as a guide for the interview. The interviewee is therefore allowed to speak without limit as in a conversation. The semi-structured interview uses an interview schedule, which is not followed strictly in order. The interviewee is also allowed to go beyond the scope of the guide and follow up questions that are not included in the guide may be asked. There is a wide variability between these two forms of qualitative interviews. The choice of one or the other is dependent on the focus of the research and the number of researchers conducting the study. For this study, semi-structured interviewing was used at the mid and lower levels of implementation to maintain consistency across all the interviewed groups (Bryman, 2008).

Qualitative in-depth interviews were employed to obtain the perspectives of policy makers at the national level, health service managers at the national, regional, district and sub-district levels and frontline health providers – community health nurses, community volunteers and community leaders. The interview schedule addressed the processes leading to the emergence

of CGP as a priority programme and its downstream implementation at the district level; participants' understanding of equity and the government's policy thrust on a pro-poor focus; and participants' perspectives regarding the importance of pro-poor programmes as well as how CGP is structured and delivered to reach the poor. These issues were included in the interview schedule, to ensure that the material needed to address each of the research questions was captured (Bryman, 2008). The interview also generated information on the background of the participants to provide the required context within which the responses could be situated during the analysis. The interview guide was thus developed with the aim of addressing these issues.

In addition to these matters, there were further considerations in the development of the interview schedule. For instance, it needed to be structured such that there was order in the questions so the interview flowed naturally. There are three stages in the interviewing process – the initial, intermediate and ending questions -, with different kinds of questions used in each stage. There are introductory questions to introduce a topic; follow–up questions - probing, specifying, direct and indirect questions to obtain more specific details; structuring questions to move to another topic; and interpreting questions to obtain understanding (Legard et al., 2003). The different questioning types were included in the interview guide to facilitate the discussion, obtain more details and provide deeper understanding. The interview schedule was piloted in one community and some adjustments were made to facilitate the understanding and ensure a smooth running of the interview process.

Focus Group Discussions

A focus group discussion refers to an interview with several people on a specific topic. This differs from group interviews in that it is more focused on a particular topic as well as being interested in the interactions between the group members, because these lead to the building of reality (Bryman, 2008). Focus group discussions are useful when people are known to have a certain common experience. They also help in understanding why people feel the way they do, and how people collectively make sense of various social phenomena and so, construct a

meaning around it. This was helpful for understanding the community perspectives of poverty and vulnerability within the society and how this influences access to services, particularly for children.

3.4.6 Preparation for interviewing

Adequate preparation is crucial for the conduct of a successful interview (Bryman, 2008). The interviewer must be familiar with the setting within which the interview is to be conducted and ensure there will be adequate privacy and quiet in advance. The interviewer also needs to 'pilot' the questionnaire prior to the conduct of the actual interview so as to become familiar with the flow and anticipate difficult or problematic questions, as well as practise good interview skills. There must be a good recording device, which the interviewer knows how to operate very well. Also, the interviewer should anticipate certain challenges that come up during the interview and identify potential solutions prior to holding it. These preparatory steps were, therefore, adhered to prior to the conduct of the interviews for this study.

In line with these recommendations, the research assistants in this study were carefully selected, trained and oriented to ensure successful interviews and focus group discussions. Four research assistants were selected in consultation with expert qualitative researchers working in the Health Research Centre of the Ghana Health Service, to conduct some in-depth interviews and focus group discussions at the district, sub-district and community levels. All the research assistants had prior experience in the conduct of qualitative interviewing and focus group discussions. They were trained over a four-day period prior to the data collection. The training agenda included an overview of the background, aims, objectives and methodology of the study in order to provide the context. There was also a clear explanation of the data collection approaches – qualitative interviewing and focus group discussion – that were relevant to the study. The research assistants were then given instruction on each of the different tools (interview and discussion guides) along with the information sheets and consent forms that were required for the study to proceed. Care was taken to review every question with the team to ensure there was clarity and a common understanding among the research assistants. We then went on to review these questions in the Akan language to ensure the right

meaning was conveyed in the process. All these actions were carried out to ensure the research assistants were familiar with the content of the tools.

The next phase in the preparation was the field testing of the questionnaires, which was conducted in a community in the suburbs of Accra – an area not included in the actual study. I wrote a letter to seek the permission from the District Director of Health Services to utilise one of the community clinics in the catchment area to field test the tools. These community health workers, in turn, facilitated the recruitment of a community volunteer, community leader and mothers for the field testing of their respective interview and discussion guides. The field testing enabled the research assistants to try out the interview and focus group discussion guides so as to become familiar with the flow and to identify problematic questions that required rephrasing or some further clarification. It also provided the opportunity to test out and become familiar with the use of the recording devices. During the field-testing, all the members of the team made notes and annotated the guides indicating the sections and questions that needed to be rephrased, where additional questions were required to enhance the investigation and any other modifications that were needed. After the field-testing, the team met to evaluate the process and identify the lessons to guide the field work. We reviewed the guides and modified them to help with the flow and understanding. The field-testing also enabled me to obtain inputs from some of the stakeholders to refine my research tools. It was a key step in the preparatory process, providing the opportunity to familiarise ourselves further with the research tools and receive inputs from stakeholders.

The final phase in the preparation was the orientation on the processes to meet and engage with stakeholders during the data collection. During this stage, I discussed with the research assistants, the gatekeepers at the different levels - district, sub-district, and community - and the entry strategies required at each level. Prior to beginning the research, I had sought and obtained permission from the Regional Director of Health in the Central Regional Directorate of the Ghana Health Service to carry out the study in the two selected districts. It was stipulated that the research assistants needed to follow a set protocol at each level they were to visit, the contents of which were discussed and agreed upon prior to the field work. The team also had

copies of the letters granting permission from the Ghana Health Service Ethical Review Committee and the Central Regional Director of Ghana Health Service to conduct the study. The copies of these letters can be found in Appendix 2 of this thesis. The orientation served to provide guidance to the team on the engagement of stakeholders and participants in the conduct of the fieldwork.

3.4.7 Data Collection

The data collection was carried out in two phases. As the principal researcher, I conducted the interviews at the national and regional level, whereas the team of research assistants conducted the interviews at the district, sub-district and community levels. My conduct of the national level interviews was critical in gaining access and engaging with the elite participants (Harvey, 2011). All the field work was undertaken in July 2014. The national and regional interviews were conducted between 08 -17 July 2014 in Accra and Cape Coast respectively, whereas the district, sub-district and community interviews were conducted over a week from 14 – 18 July 2014 in the Mfanstiman and Gomoa East Districts in the Central Region. The research assistants travelled to the Central Region and stayed in these districts to facilitate the engagement with the stakeholders and participants. This enabled them to have adequate time and also provided the flexibility for the conduct of the interviews at the times that were suitable for the participants.

The first district the team visited was Gomoa East and they arrived in Swedru, the district capital of Gomoa East District of the Central Region on Sunday, July 13th 2014. The following morning, team members made a visit to Obuasi Gomoa (Afranse) to pay a courtesy call on the District Director of Health, of Ghana Health Service, Gomoa East District. The team did not meet the District Director, but the Officer in-charge of the clinic to introduce themselves and to inform them of the purpose for the visit. The District Director was informed through a phone call and permission was granted. The other district staff to be interviewed were also informed via phone. The team interviewed the sub-district head of Buduata sub-district and the District Public Health Nurse and the District Nutrition Officer at the district level. They then visited the

Abasa and Aboyin communities to meet and interview the community health providers, community volunteers, community leaders and caregivers. The community health providers (community health nurses) are based at the Abasa Community Health Planning Services (CHPS) compound and have oversight of the Aboyin community. A community health nurse was therefore interviewed at Abasa. Another community health nurse accompanied the team to the Aboyin community and introduced them to the community volunteer and the opinion leaders. The volunteer, in turn, helped the team to recruit some caregivers for the focus group discussion. The second group of communities the team visited in Gomoa East District were Potin and Takyiam. The team first went to the Potin CHPS compound that has oversight of the Takyiam community. One community health nurse was interviewed in this compound and other staff took the team to the other community - Takyiam. At Takyiam, the team interviewed the community volunteer, community leaders and conducted a focus group discussion with the caregivers. This brought to a conclusion the data collection in Gomoa East District. A total of nine interviews and two focus group discussions were conducted in the district.

The team travelled to Mfanstiman District after completing the data collection in Gomoa East. Here, the team met with the District Director of Ghana Health Service for Mfantisman, formally explained to her the purpose of the visit and arranged for an interview with her. A district health officer was assigned to accompany the team to the first community, Kormanste. In this community, the team interviewed a community health nurse in the community clinic, a community leader, a community volunteer and conducted a focus group discussion with the caregivers. In my capacity as principal investigator, I joined the team and observed them as they engaged the participants and conducted interviews along with focus group discussions. Through this interaction, I gained some insight into the community and was able to provide some useful feedback to the team regarding the interviewing and FGD. The second community the team visited in Mfanstiman District was the Dominase community. The team had an opportunity to witness a child welfare clinic session and gain some insight into the community growth promotion in that particular community. In this community, the team interviewed the community volunteer, community leaders and caregivers. During the recruitment for FGD participants, the volunteers were asked to identify a few caregivers, who were failing to attend

growth promotion sessions so as to gather the perspectives of a range of caregivers. After the FGD, two of those caregivers were interviewed individually to understand their concerns. The work at Dominase brought to a conclusion the data collection in the field. A total of eleven interviews and two focus group discussions were conducted in the district.

From the interviews and focus group discussions, information was obtained on the perspectives of health services for the poor; the community growth promotion and how it addressed the needs of the poor. At the national, regional and district levels, the perspectives of the national pro-poor policies and strategies and their perceived relevance as well as their application were obtained, whereas at the sub-district and community levels, information was obtained on the perceptions of providing services to the poor. The health workers and volunteers at all levels provided information on their knowledge, involvement and perception of the community growth promotion initiation and implementation. In particular, robust information was gathered on the way in which it addressed the needs of the poor, as well as how services could be improved to meet their needs. At the community level, in addition to the perceptions of the CGP services, information was obtained on the perception of poverty, barriers to health care for the poor and solutions for addressing these barriers.

3.4.7 Data Recording and Transcription

The in-depth interviews and focus group discussions were all recorded and transcribed. This had several advantages (Bryman, 2008): it provides a detailed account of the interview, which helps to fill in gaps where the interviewer may not remember. It also allowed the interviewer to observe and note other non-verbal signs during the interview. In addition, the existence of the record enables repeated and more thorough examination, as well as reuse of the data obtained. The recorded data was transcribed by a team of three assistants with experience in transcribing qualitative data. They were included in the training sessions for the data collectors so they would have an overview of the research objectives and methodology as well as become familiar with the tools for data collection. A few of the transcripts were reviewed and verified with the recorded data to ensure consistency. Whilst the data collection involved the conducting of four focus group discussions, one of the data recordings became corrupted and

hence, could not be transcribed. The analysis was therefore based on the three transcribed FGD. This was not considered to affect the integrity of the data, as in the initial proposal just two FGD had been planned. There was a similar occurrence with the in-depth interviews of the volunteers which were conducted, where one recording was misplaced and hence, three out of the four of these were transcribed and included in the analysis. Thus, even though the data recording and transcription was, on the whole beneficial, there were challenges in its use, as observed in the above description. Despite these limitations, the available transcripts provided a wealth of rich data for analysis.

3.5 Data Analysis

There is an iterative process between data collection and analysis (Carter, et al., 2009), and in this case, the analysis of the data began during the data collection and continued throughout the report writing phase. The purpose of the data analysis was to examine the transcripts and notes which formed the dataset and explain and interpret them to make meaning of them (Pope et al., 2000). As the qualitative researcher during the analysis I had to "provide some coherence and structure to this cumbersome data set while retaining a hold of the original accounts and observations from which it is derived" (Ritchie & Spencer, 1994, p. 176). There are a number of steps in the data analysis process, including indexing, developing analytical categories and theoretical explanations and analytic induction (Pope et al., 2000). There are different approaches to developing the categories and how these interact with the theory: these categories may be derived from the data inductively or deductively from the research questions or objectives (Pope et al., 2000). One inductive method of analysis is known as "grounded theory". Deductive analysis is not commonly used in qualitative research, and is associated more with the framework approach (Pope et al., 2000). There are other forms of analysis used in qualitative research, such as narrative analysis, discourse analysis and thematic analysis (Smith, et al., 2009; Braun & Clarke, 2006). The framework approach was the analysis approach adopted for this study as it facilitates systematic analysis, is highly analytical and allows transparency in the analysis process (Ritchie & Spencer, 1994). It is also recommended

for applied policy research (Pope et al., 2000; Ritchie & Spencer, 1994), and allows a combination of deductive and inductive approaches in the analysis of the data.

The Framework Approach to the Analysis of the Qualitative Data

The "framework" approach is an analytical process that has clearly defined stages. Despite being systematic with clearly defined steps, it requires the creativity and intellect of the analyst to give meaning to the findings. The key features of the framework approach are shown in table 3-1:

Table 3-1: Key Features of the Framework Approach

Grounded or generative: it is heavily based in, and driven by, the original accounts and observations of the people it is about.
Dynamic: it is open to change, addition and amendment throughout the analytic process.
Systematic: it allows methodical treatment of all similar units of analysis.
Comprehensive: it allows a full and not partial or selective, review of the material collected.
Enables easy retrieval: it allows access to, and retrieval of, the original textual material.
Allows between- and within-case analysis: it enables comparisons between and associations within cases, to be made.
Accessible to others: the analytic process, and the interpretations derived from it, can be viewed and judged by people other than the primary analyst.

Source: Ritchie & Spencer (1994, p. 310)

The data analysis in the "framework approach" is carried out in five stages: familiarisation, identifying a thematic framework, indexing, charting as well as mapping and interpretation (Pope et al., 2000; Ritchie & Spencer, 1994). Gale et al., (2013) include transcription as the first step in the framework analysis and therefore, have six steps instead of five (Gale et al., 2013,). In this account, my approach was to use the five steps. For the first step, familiarisation, I reviewed all the data, reading the transcripts and field notes, and listening to some of the tapes, so as to become very familiar with all the data. During this process, I started to make notes indicating key ideas and recurrent themes that were emerging from the data. During the

second stage, that of identifying a thematic framework, I reviewed the notes made in stage one and identified key issues, concepts and themes against which the data could be assessed. To develop this framework, I drew on issues regarding which I was already aware of prior to the data collection in relation to the research question, theories around the subject as well as emergent issues from the respondents and analytical themes from the research; thus combining deductive and inductive approaches. Initially, there were several themes, but these were subsequently reduced in number and made more concise. Once developed, the thematic framework was employed to process the data. The finalised thematic framework and the descriptions are shown in table 3.2.

Table 3-2: Thematic Framework

CODE	DESCRIPTION
Dimensions of equity issues in the community growth promotion programme in Ghana	
Philosophy of Equity	
Pro-poor health policies	*Perception of national policies and various approaches that are considered pro-poor, such as the community approach, universal access by increasing financial access (health insurance, exemption policies) services close to clients, programmes targeting hard to reach areas or targeting deprived districts and social interventions , e.g. LEAP, that are addressing and monitoring indicators of inequity*
Relevance of pro-poor policies	*Perceived relevance, application and benefits of national policies on poverty, such as in planning, resource allocation, prioritisation, increase in access, achieving health outcomes, universal coverage, community participation and identifying deprived communities*
Equity in service delivery / Reaching the poor with health services	*Perception of provision of health services for the poor and descriptions of health services to the poor*
Experience of implementing community growth promotion focusing on the poor and marginalised.	
Agenda setting – Initiating CGP	*Key factors considered in the decision-making and prioritising of CGP, such as disease or malnutrition burden, access to care, criteria for selection of: regions, districts and communities for implementation*
Formulation of CGP	*Objectives of CGP, such as technically to improve nutrition and to Improve participation levels*
CGP Services	*Perception and description of services provided by community growth*
CGP Services to the Poor	*How the poor benefit from the services provided, such as no need for transport to access service*
Stakeholders' Experience	*Experience of stakeholders in service delivery (e.g. volunteers as community mobilisers in terms of the sacrificial nature of work, community appreciation and trust, pride in their role and anger against those who do not appreciate their work)*
Roles played by different actors	*Description of the different roles, e.g. other sectors, such as community development, to determine who needs the service* *Ministry of Health at national, regional and district levels involved in resource mobilisation, targeting and supervision and implementation* *Community level - committees, traditional leaders as advocates, assembly men and faith groups*
Benefits of CGP	*Perceived CGP benefits, such as community ownership, critical link in service delivery and the continuum of care, provision of comprehensive service, entry point for other interventions, access of formal health workers to better knowledge of community and multi-tasking of volunteers*
Utilisation of services	*Barriers affecting utilisation of services, such as times clashing with income-generating activities, embarrassment of caregivers when child is not growing well, caregivers not having appropriate clothes, poor attitude of health workers and out of pocket payments*
Sustaining services at the Community level	*Perceived approaches required for sustained service delivery at community level, such as resource allocation, community engagement and participation avoidance of parallel systems*

To understand the factors that influence the uptake of the intervention among the poor at the community level	
Defining Poverty	*Criteria of poverty, such local identification of deprivation, pockets of deprivation, seasonal / fluctuating / temporary nature of poverty, community health workers' observation of social factors in communities, vulnerability as a measure of poverty, people who cannot come close to health services, remoteness of community, burden of disease and occupation in the community*
Barriers to care for the poor	*Barriers to care for the poor, such as cultural, financial, geographical, gender, illiteracy and the intimidating formal health care system*
Health System challenges in reaching the poor	*Challenges with operationalising pro-poor policies and interventions, Health system challenges in reaching the poor, such as limited resources in service delivery to the poor, not defining the scope and areas of need, low motivation in reaching the poor when coverage of interventions is high and instability in poor communities*
Improving care for the poor	*Ways of improving care to the poor, such as targeting them, client friendly services, community empowerment, integration of services addressing the poor and availability of human resources in poor or deprived areas*

Source: Analysis of the Researcher's Fieldwork Data

In the third stage, indexing, the thematic framework was applied to the data in textual format. This stage was undertaken using NVivo 10 software, with the assistance of a qualitative research assistant to ensure transparency in the process. I imported the transcripts into NVivo 10 software and entered the thematic framework into the software. The qualitative research assistant then, using the dataset, systematically went through each transcript, highlighting key sections of the text and selecting as well as linking them to the appropriate code in the framework. I provided the assistant with an expanded framework linking the interview / focus group discussion questions with the thematic framework and the descriptions to provide guidance in the indexing. A section of this framework is shown in table 3-3.

Table 3-3: Section of the expanded Framework linking Questions with thematic framework

Question	CODE		DESCRIPTION (Responses provided in the transcripts)
	1.0	Dimensions of equity issues in the community growth promotion programme in Ghana	
	1.1	Philosophy of Equity	
What do you think about providing health services for the poor? How do the poor use the services you provide?	**1.1.1**	Equity in service delivery/Reaching the poor with health services	Perception of provision of health services for the poor and descriptions of health services to them
Do you know any national policies or strategies that are aimed at improving health services to the poor?	**1.1.2**	Pro-poor health policies	Perception of national policies or various approaches that are considered pro-poor, such as the community approach, universal access by increasing financial access (health insurance, exemption policies) services close to clients, programmes targeting hard to reach areas or targeting deprived districts, social interventions, e.g. LEAP as well as addressing and monitoring indicators of inequity

Source: Analysis of the Researcher's Fieldwork Data

In the fourth stage of charting, the analyst seeks to construct a pictorial view of the entire dataset. For this study, the data from the original context was organised according to the thematic areas identified in the thematic framework. Using the N-Vivo 10 software, framework matrices were created that organised the text from each transcript according to the themes and sub-themes. The framework thus comprised a row per transcript and a column per sub-theme. Using these matrices, I was able to identify and abstract the key issues and concepts from the data, as well as interesting quotations to illustrate these points. Finally, in the last stage of mapping and interpretation, the key objective of the qualitative analysis was considered and theoretical concepts, associations and causalities emerging from the data were identified. This stage was guided by a number of theoretical frameworks, which were used to help structure and organise the themes identified from the data.

As a beginner qualitative researcher, I found the framework method to be a very useful tool to enable me manage and make meaning of a significant amount of data in systematic way. This

framework allowed me to maintain a deductive and inductive balance in the analysis of the data and my overall research.

3.6 Quality Criteria for Qualitative research

There is no agreement amongst scholars on the criteria for ensuring quality in qualitative research. Various approaches have been proposed, for example, applying quantitative criteria, such as reliability and validity, applying alternative criteria of trustworthiness and authenticity or applying a middle ground between the first two opposing views, which is referred to as "Hamersley's subtle realist account" (Bryman, 2008). Those advocating for the quantitative criteria do this from a realist point of view, whereas those who advocate the use of alternative criteria do so from an anti-realist perspective (Mays & Pope, 2000).

Reliability and validity are applied in a specific manner in qualitative research (Bryman, 2008). External reliability refers to the degree to which a study can be replicated. In qualitative research, a researcher seeking to repeat the study needs to replicate the process engaged in by the original researcher to achieve this. To enhance the external reliability in this study, I clearly described the methodology and all the steps and processes so that it could be replicated. Internal reliability implies the extent to which members of the team agree on what they see and hear. In this study, all the members of the data collection and transcription team were oriented on the study objectives and the data collection tools to ensure a common understanding. In addition, all the interviews and the focus group discussions were recorded to ensure verbatim reports from the participants were obtained. Internal validity is an indication of whether there is a good match between the researchers' observations and the theoretical ideas developed. This usually is high for QR as researchers spend a lot of time with the participants. In my capacity as principal researcher I did not come into direct contact with all the participants, however, by reviewing the transcripts and recordings, I became very familiar with their perspectives. It should also be noted that the external validity, which refers to the degree to which the findings of this study can be generalised, is low. This is usual in QR, which

involves typically case studies and small sample sizes. Despite the limited external validity, there were a number of actions taken to enhance the reliability and validity of the study.

Guba and Lincoln (1994) suggest as alternative criteria to reliability and validity, trustworthiness and authenticity, whereas Daly and Lumley (2007) propose that the quality depends on "four key steps in the research project":

> …devising a framework for the study based on a review of the health literature but also on the relevant social theory literature; using this framework to draw a strategic sample from the population to be researched; having methods of analysis that produce an interpretation of what was said in interviews, not just a description; and finally, reporting of the research, drawing conclusions that properly acknowledge the methodological limitations of the study (Daly & Lumley, 2007, p. 203).

Despite these differences, there is widespread consensus on the importance of maintaining rigour in qualitative research. There are a number of ways to enhance this and the credibility of qualitative research, such as triangulation, respondent validation, clear exposition of methods of data collection and analysis and reflexivity (Mays & Pope, 2000), which were applicable to this study. Triangulation refers to the use of more than one method of data collection or data source for qualitative research, such that the data obtained from one source substantiates the other. The assumption is that the weaknesses of one method or data source may be compensated by the other, though this is not always the case (Mays & Pope, 2000). In respondent validation, participants in the research review the researcher's work and ascertain the level of agreement. This, however, may be limited by the different roles of the study participants and the researchers and consequently, their varied perspectives.

In this study, I applied a number of the recommended techniques to enhance the rigour and credibility of my research. Firstly, I utilised number of different data collection methods, namely, documentary analysis, in-depth interviews and focus group discussions, which served to corroborate the data. Secondly, by stating clearly and in detail the methods I used in data collection and analysis, I enabled other researchers to follow the processes used in the research

so as to ascertain whether the conclusions drawn were robust (Mays & Pope, 2000). Thirdly, I acknowledged my own biases and subjectivity, which may have influenced the conduct of the research and the interpretations drawn from it. In sum, my application of these techniques enhanced the rigour and credibility of this research endeavour.

3.7 Ethical Issues

There were a number of ethical issues that needed to be addressed prior to the conduct of the study, and during the various stages of its execution, namely, the beginning, data collection and analysis as well as in relation to reporting, sharing and storing the data (Cresswell, 2014).

3.7.1 Ethical Review

I sought ethical approval from the University of Bath, Research Ethics Approval Committee for Health (REACH) as well as the Ghana Health Service Ethical Review Committee. My research proposal was subsequently modified so as to take into account the feedback and comments from these committees. In addition, I sought permission from the leadership of the Ghana Health Service – at the national level and the regional level - to use their sites and interview their staff at their facilities during the study. In the targeted districts, the data collectors paid a courtesy call to the District Directorate of the Ghana Health Service to inform them of the team's presence and seek their approval to work in that district. Also, at community level, the data collectors called upon the leaders prior to engaging the community members. All these actions were taken to ensure the appropriate courtesies and protocols had been accorded to the gatekeepers and key stakeholders at all the levels of engagement.

3.7.2 Informed Consent

Informed consent was obtained from all participants recruited for the study. An information sheet was developed explaining the research objectives, methods and participation process to the potential participants. The information sheet was translated into the local language, Twi and where those targeted did not understand English language, the interviewer translated the information into the local language. The potential participants also had the opportunity to ask

questions. It was crucial to ensure that all those recruited participated out of volition and not under obvious or subtle coercion. Participants within the community were provided with water to drink during the interviews and focus group discussions. It was initially planned to provide the participants with refreshments, however, based on the guidance received by experienced qualitative researchers, they were given a cake of bathing soap, which was approximately the cost of the proposed refreshment. They indicated their willingness to participate in it by signing or thumb printing a consent form. No funds were paid to any participant for the study at any level.

3.7.3 Confidentiality

This research could raise concerns about the invasion of the participants' privacy. There could also be issues regarding confidentiality raised by us having probed the quality of care received by the subjects. However, the participants were assured that information obtained was to be kept confidential. Due to the small number of participants to be interviewed there was the possibility that some might have been identified as having participated on account of their known position in the health system. To address these issues, the recordings were given numbers according to the coding system developed and the transcripts labelled as such. A process of anonymization removed names and where possible, identifying information from the interview transcripts. In addition, the transcripts were kept confidential and access given only to the research assistants, who carried out the various aspects of the data collection and transcription. The framework analysis produced findings across all the transcripts and consequently, no information can be directly linked to individual participants. All the transcripts were kept securely by the principal researcher to ensure confidentiality was maintained.

3.8 Limitations of the study

There were a number of limitations of the study. Firstly, as a qualitative case study in a limited setting with a small sample size, the extent to which the findings can be generalised is low. Also, the research was limited in terms of the scope of participants included in the study. Despite the CGP involving several actors, including development partners, such as the World Bank and other high level government officials, not all of them were included in the data

collection and thus, there may have been limited scope in the captured perspectives. There were also some limitations in relation to the type of data collection methods used in the study. That is, whilst the interviews provided information from the perspective of those interviewed, this could have been limited due to their restricted worldview. Secondly, with the conduct of the interviews, information was obtained in a designated setting with a researcher and no observations were included in the research process that could have verified or refuted the responses provided. Thirdly, the presence of the research assistants might have biased the responses of the participants in that they could give them the answers they think they want to hear. Despite these limitations, the methodology, due to the use of different data collection methods, transparency in the process, and reflexivity, had sufficient rigour and validity to render the study findings credible.

3.9 Summary of Methodology

In this chapter, I have described in detail the research methodology used for the study, providing an overview of the qualitative research and my rationale for utilising it in this study. I have also explained the study design, data collection and analysis procedures as well as the ethical and confidentiality issues raised in this study. This detailed description of the methods is to provide the reader with the context of the study as well as the possibility of evaluating the extent to which the conclusions drawn from the study are sound. In the next three chapters, I present the findings of the research.

4. Findings – The philosophy of health inequity amongst the health providers

4.1 Introduction

This chapter is the first of the empirical chapters presenting and discussing the findings from the interviews. Attention is focused on understanding the perceptions of key stakeholders and actors regarding the broad philosophy of equity and its implications for health service delivery to the poor This chapter therefore addresses the research question: "*What is the perception of health workers and volunteers at all tiers in the health system of health equity issues*?" The chapter begins with a brief description of the participants and their role in health service delivery. This is followed by analysis of the components of the thinking and understanding of issues relating health care for the poor, drawing upon qualitative data obtained from interviews and showing commonalities and variations in the accounts of the recipients. The concluding part of the chapter highlights the key points from the findings, and the contribution to the knowledge made on health equity through this research.

4.2 Description of Participants

This chapter focuses on the findings from the in-depth interviews with health workers at national, regional, district, sub-district and community levels as well as community volunteers. The findings of the community leaders as well as focus group discussions with caregivers of children under the age of five are presented and discussed in the subsequent chapter. The participants from the Ministry of Health (and Ghana Health Services) included senior level staff, including directors, deputy directors and programme managers, mid-level management, such as regional and district officers and community health nurses, who were involved in direct implementation. At the community level, the participants included civic and other opinion leaders as well as volunteers who were mainly in farming. The majority (three-quarters) of participants from the MOH were female, whereas the majority (about 60%) from the

community level were male. The ages of the participants ranged from 24 – 70 years. The details of the participants are shown in tables **A-1** to **A-5** in Appendix 4.

4.3 Empirical Basis

The importance of the actors and stakeholders in the policy process has been highlighted in the chapter on the methodology of this study. Understanding the perspectives of the actors is crucial in the policy analysis process and thus the empirical basis for this chapter can be summarised in the words of Buse (2008) as: *"The assumptive worlds of policy-makers, influencers and implementers are all important in the social construction of the problem and the policy."* (p. 355). This chapter therefore focuses on the "assumptive worlds" or perspectives of the participants of poverty and its implications on health inequity, which is the problem and the policy solutions.

In the policy triangle framework, the actors are placed at the centre of the triangle indicating to an extent their importance in the process as well as their influence and vice versa regarding the other components of the triangle (Walt & Gilson, 1994). These actors can be categorised into governmental actors – politicians, civil servants, bureaucrats; non-governmental actors – professional bodies, trade unions; pressure or interest groups; international actors – multilaterals, bilateral agencies; academia, media and citizens as well as members of civil society (Walt, 1998). Whilst a wide range of stakeholders may have influenced the policy process, this chapter focuses on the policy formulation actors - governmental officials (civil servants) from the national level of the Ministry of Health and the Ghana Health Service along with implementation actors at the regional, district, sub-district and community levels of the health sector. There are some overlaps in these categorisations, such as with the community volunteers, who are community members but engaged by government actors in their role. Also, the regional and district actors do have a role to an extent in formulating the policies at their respective levels.

Walt (1998) indicates that the extent of involvement and influence of the stakeholders in the policy process is determined by the issue at stake, the context as well as the perceived advantages or disadvantages to the actors. The study of the actor dynamics in the policy process is, consequently, a crucial aspect of the policy analysis approach. The literature on health policy analysis focusing on actors has examined a number of aspects, which are summarised by Gilson and Raphaely (2008, p. 299) as follows:

- *'Local and national level actors' views about the extent of actor participation in health policy processes;*
- *How the interests, values and beliefs of different actors shape the implementation of policies including public health care providers and managers, private doctors and beneficiaries;*
- *How in implementation, health staff resist and reformulate a range of policies".*

Buse (2008) however, adopts a slightly different approach in his analysis of the actors in the policy analysis approach. His proposed approach of real-time analysis utilises a policy influencing framework made up to two separate parts, the policy analysis and the policy engagement approaches, focusing on the retrospective and prospective aspects, respectively, with the former influencing the latter. In his distillation of the policy analysis approach, drawing on a number of authors, the variables of interest with regards to the actors are their scope, the way they are affected by the policy as well as their underlying interests, power, positions and commitment. In the policy engagement aspect, he proposes actor engagement utilising the information from the retrospective analysis including their perceptions of the problem and solution. Common to the two approaches is the importance of recognising the stakeholders at all levels, understanding their perspectives and how these influence the policy process. Drawing on these summaries of the literature on policy analysis (Buse, 2008; Gilson & Raphaely, 2008; Walt, 1998), this chapter accordingly focuses on the interests, values, beliefs of the actors in regard to the policy issue (problem) and the proposed solution. The perspectives of the health service providers - their values, beliefs and interest on the issue of health inequity, the solutions to addressing the problem and the relevance of these are analysed.

Understanding these perspectives is crucial as they influence the implementation of the equity oriented strategies (Scott et al., 2012).

The analytical approach utilised in this study is the framework approach, which was described in detail in the methodology chapter (Ritchie & Spencer, 1994). This is combines both deductive and inductive approaches and thus, involved drawing on the research theories and issues prior to data collection, as well as the themes from the data to develop a thematic framework which is used for the analysis. The findings are accordingly analysed and presented according to the key themes and sub-themes identified from this framework, with differentiation across national, district and community level participants.

4.4 Findings and Discussion

4.4.1 Perspectives on Equity in Health Service Delivery

There were various perspectives held by the health care providers, including the volunteers on health equity issues and reaching the poor with health care. These included the recognition of the poor needing attention in health care; national prioritisation of health equity; the challenges faced by the poor in health care; the varying nature of poverty; the perceived role of the participants in addressing the health care needs of the poor. These are presented and discussed in sequential order.

4.4.1.1 Concerns of poor people requiring some attention in health service delivery

Twelve out of eighteen of the respondents felt that that poverty, health and inequities were of key concern. This was reflected by one national level participant in the following words: "*And so we know that there are some that are unable to pay the premium. There are the poor deprived that are not being reached" (IDI-NA-03).* Whilst this was recognised by all stakeholders at the national level, it was less the case at the district and community levels, where three out of

seven; and four out of six respondents, respectively, acknowledged it as being an issue. At the sub-national levels, (regional, district and community), the concerns seemed to be influenced by their recognition of poverty in the community and the challenges faced by the poor and deprived in accessing services. At the national level, this concern seemed to be driven more by the knowledge of national policy prioritisation of action against poverty. The different drivers of the actors' views at the national and sub-national levels may account for the disparity in the attention to poverty, health and inequity at the respective levels. **Table 4-1** in the ensuing text shows a summary of the responses of the participants on their perspectives of health care for the poor.

Table 4-1: Summary of perspectives of policy formulation and implementation actors of poverty and equity issues: Perception of health care for the poor.

		Percentage of respondents at the different Levels		
Perspectives on poverty and equity (mentioned in the interviews) (Number of targeted respondents – 18)	**Number of targeted respondents (18)**	**National level (No-5)**	**Regional and district level (No-7)**	**Community level (No-6)**
Perception of health care for the poor.				
Recognition of poor people requiring some attention in health service delivery	12	5	3	4
Pro-poor as a priority issue of the government	4	4	0	0
Regional perspective of poverty	2	0	1	1
Equal care for all	1	0	0	1

Source: Author's fieldwork data

4.4.1.2 National Prioritisation of Health of the poor and marginalised

The stakeholders at the national level considered addressing the health needs of the poor a national priority and of importance to the government. This was expressed by a national level participant as follows: *"….the Ministry itself is very key with pro-poor interventions" (IDI-NA-01).* This viewpoint was common across the national level actors and seemed to be a key driver influencing their perspectives on health equity and the poor requiring attention in health care delivery. This position held by these stakeholders, was most likely influenced by the fact that the prioritisation of the health of the poor has been on the national health agenda in Ghana for several years. The five year programme of Work for 2002 -2006 had as its theme, 'Partnerships for Health: Bridging the Inequalities Gap' (Ministry of Health, 2002). The subsequent programmes of work of the Ministry of Health maintained this focus on equity (Ministry of Health, 2008) (Ministry of Health, 2013). A reference to this was made by a national level policymaker as follows:

> *"So the mission of the sector has not changed any way, but at least the current five year programme 'woho se' (vernacular – meaning you can see); ...current medium health sector plan has a component of certain interventions, social protection and other things for the poor." (IDI-NA-05)*

The statement above not only shows awareness of the national agenda, but also gives a sense of how this is leading to actions for the poor. This pro-poor perspective, as reflected on the national agenda, was expected to influence the implementation and scale up of some programmes to ensure they focused on and targeted the poor. In scaling up the community growth promotion (CGP) programme, the national level health care workers expected that regions and districts would consider the remoteness of the communities, access to services and the prevalence of disease conditions associated with poverty such as malnutrition. In the words of a nutrition programme officer at the national level:

> *"….because it is kind of pro-poor..., first, they would look at the remoteness of the communities in terms of the nearest hospital; they would look at the prevailing*

malnutrition situation and other indicators of..., I mean, that show that they have access to hospitals, before they select the communities" (IDI-NA-02).

The pro-poor agenda was also considered very much in regards to the implementation of the Health Insurance Programme, in that the government sought to ensure that it addressed their needs. This was expressed by a national level participant as follows:

".....the government is trying to make sure that the health insurance addresses the needs of the poor. And so we know that there are some that are unable to pay the premium. There are the poor deprived that are not being reached. And the strategy of government is one that the health insurance is registering that poor" (IDI-NA-03).

There was generally consensus amongst the national level stakeholders that addressing the needs of the poor was a national priority and this was reflected in their perspectives on health services for the poor. Considering the relatively long time pro-poor issues have been on the national agenda, it is not surprising that the national actors were very much apprised regarding this agenda. What is surprising is the relatively limited attention and appreciation of this agenda at the lower levels of the health care system, i.e. at the regional, district and community levels. This implies, to an extent, that whilst the issues of poverty and health inequity have been very high on the national agenda, the dissemination to the district and community levels appears to have been weak. The weak dissemination of national priorities to the actors in the district and community levels of health sector may have implications on the successful implementation of policies arising from those priorities. McIntyre and Klugman (2003) showed that the effective communication of new policies to lower-level managers and frontline health workers was a critical motivator factor in implementing them. The policy process is affected by actors' interpretation of the underlying problems and the policy objectives (Buse, 2008), hence the importance of effective communication of the national priorities driving the policy agenda (McIntyre & Klugman, 2003). In sum, the responses from the national actors on their perspectives regarding poverty reflected an acceptance of the existence and challenges of health inequities and consequently, addressing it was considered a high priority by the national

government. This priority, however, had not been effectively communicated to the lower levels of implementation.

4.4. 1.3: Recognition of Poverty at District, Community level

At the district and community levels, there was perception amongst some actors of the prevalence of poverty in the community and the challenges it posed to accessing health care. Under half of the participants, who were all from the sub-national levels, gave some indication of the challenges faced by the poor in accessing services. These challenges included transport costs, expressed by a community volunteer as follows: "*my opinion on that is it helps them (outreach services), not everybody can get that money and take a car to the hospital …*" (IDI-CV-MF-01). There were also health care costs associated with accessing services for the poor, as indicated by another community volunteer: "it *is all about money, so because of that, some people won't come no matter how long you speak to them and moreover, if the person comes he will be given a bill to pay then he won't come at all* " (IDI-CV-GE-02). These geographic and financial barriers to health care faced by the poor are known in the literature (Wagstaff, et al., 2004), which shows that the poor tend to live further away from health facilities and consequently, have lower coverage of interventions (Schellenberg et al., 2008). In addition, the existence of out-of-pocket payments has been shown to be a major disincentive in relation to the utilisation of health services, particularly by the poor (Lagarde & Palmer, 2008). The recognition and acknowledgement of these barriers by the volunteers is positive as it indicates their receptiveness to the existence of these challenges and hence, could affect their preparedness to intervene.

There was the interesting perspective of one community volunteer, showing not only the need for care by the poor, but also the benefits particularly for the poor in accessing services. This was expressed in the following way:

"…. when it comes to taking good care of themselves for someone who is poor, when you advise such a person to abstain from certain things it will help the person. So, if she does not have money she will still be able to avoid getting certain diseases assuming the person has ten pesewas today. She would not use that for hospital or buy any medicine with it, even if she has health insurance, she won't go to the hospital. So, instead of spending money on hospital, she can take care of the child with that money or even spend the money on agricultural activities, so this helps the poor in this community in terms of their activities." (IDI-CV-MF-01)

In addition to the challenges faced in accessing health services, there was also the recognition by two out of twelve of the participants at the sub-national of the high prevalence of poverty in the Central Region based on the national ranking of poverty and hence, some additional effort was required to reach out to the poor and vulnerable in the communities. A community health nurse put this in the following way: *"… We look at the poverty rate. We know that Central Region is…. apart from the Northern Region, Central Region is also linked to high prevalence of poverty" (IDI-CH-MF-02).* Whilst this recognition seemed to show a heightened awareness of the stakeholders at the management and health provider levels in relation to needing to deal with issues of poverty, the fact that it was mentioned by less than a fifth of the participants at the regional level is worrying. The limited attention to regional poverty by these stakeholders is again an indication of the limited dissemination of national policies and priorities to the sub-national levels. Thus, even though Central Region is one of the poor regions in the Southern part of Ghana (Ghana Statistical Service, 2007), this information had not been disseminated widely to staff working in the region and hence, was unlikely to influence their work.

In contrast to the perception held by the majority of the stakeholders that the poor required some support in accessing health service, there was the perception by a community health nurse that health care should be provided *"equally to everyone" (IDI-CH-MF-01) .* This actor did not believe in distinguishing the poor for attention, but rather the provision of services for all:

"For the poor ones… You see you cannot identify if this person is poor or rich, but as we provide services what we do equally to… we do equally to everyone. We don't specify like giving service to poor people or rich people. The same services we render to everybody." (IDI-CH-MF-01) The perception held by this health worker implies a lack of knowledge and recognition of the barriers faced by the poor in accessing health services (Wagstaff et al., 2004). This failure to understand its particular and challenges in relation to health care has been attributed to the "social distance" between the health provider and the client, whereby the health workers do not understand or appreciate the "lived reality of social disadvantage" on account of their higher social standing and position (Bloch et al., 2011). Likewise, in Ghana the health professionals are likely to come from relatively higher socioeconomic backgrounds than the poor clients they see and this could make them unaware and insensitive to the experiences of poverty and the associated challenges with accessing health care. Whilst this view was not widely held, the fact that some health workers at the community level still do not recognise the need to address specifically the health care needs of the poor should be of major concern and thus, addressed in the various pro-poor strategies.

4.4. 1.4 The different "faces" of poverty

Further to recognising the challenges faced by the poor in accessing services, is also the need to identify the poor. This is one of the key considerations in understanding and addressing issues of poverty and health inequities. The World Bank describes them as those living in a state of poverty or "pronounced deprivation in well–being" (The World Bank, 2013). There are quite a few dimensions of poverty, including monetary, housing, health, education and food aspects (Haughton & Khandker, 2009). In this chapter, whilst the focus is mainly on monetary poverty, other dimensions come to the fore as the stakeholders elucidate their perspectives. In describing the poor, the stakeholders used terms such as "deprived", "vulnerable", "hard-to-reach" and "underserved" for areas or communities thought to be disadvantaged or underprivileged in any way. This perspective of poverty, targeting groups of people in a defined locality, rather than individuals or households, is more aligned with the geographic targeting

strategy for identifying the poor (Jehu-Appiah et al., 2009). This strategy has been the common approach for reducing the equity gap between the respective regions in the Ghana Health Sector and hence, may explain the perspective of the stakeholders. The production of periodic poverty profiles within the country (Ghana Statistical Service, 2007) (Ghana Statistical Service, 2014), provides the required data to identify the poor regions and districts. Whilst geographic targeting is very effective in identifying the poor people, there may be leakage to the non-poor, with potential cost escalation. However, it is simple to administer and efficient in areas where the incidence of poverty is high (Jehu-Appiah et al., 2009). The acceptance of the concept of deprived communities by the stakeholders is a positive step as it does imply, by extension, the acceptance of geographic targeting in reaching the poor.

Beyond the concept of poor communities, an issue brought to the fore by the participants in relation to poverty was its varying degrees amongst the clients at the individual level. They did recognise that some who were not very poor, but did not have the means to access health services and consequently, needed to be assisted in doing so. In the words of one community health nurse: "*Some... some of them, they are poor but that doesn't mean that they don't have anything at all; just that they don't have the means to, as the rich people." (*IDI-CH-MF-02) On the other hand, there were others who were "*really, really poor*" and could hardly make ends meet: "*they are really, really poor they are so poor that when they are on admission and they are discharged they do not want to leave, because they do not know where their next meal is coming from…"* (*IDI-DS-MF-02).* This finding, beyond elucidating the perspectives of the stakeholders at the district and community levels, does reveal the existence of a wide spectrum of poverty at the latter level, which has implications for programmes for the poor. This finding highlights the importance of the mechanisms to identify the poor so as to ensure the complete spectrum of vulnerable people including the "not very poor" as well as the "really, really poor" are addressed by programmes. A case study of the Ghana National Health Insurance exemption scheme, for poor individuals, showed that only 2% of the insured had benefited, despite the fact that the national estimate of the poor was 18 -28% at the time (Aryeetey et al., 2010). One of the reasons for this discrepancy was the mechanism for identifying the poor. Whilst there

are different mechanisms for identification, including geographic targeting, proxy means testing (PMT), means testing (MT) and participatory wealth ranking (PWR), their respective strengths and weakness (Aryeetey et al., 2010) should guide the application to ensure no person is excluded from receiving services on account of poverty. In sum, understanding the different concepts of poverty is a key step to identifying and including the poor.

4.4.1.5: Actors' participation at the Local level to ensure Health Service Delivery to the poor

The implementation actors at district and community levels, not only recognised the health care needs of the poor, for they were also of the opinion that they had a role to play in addressing these needs. This was demonstrated by their interventions at the local level of services to increase access to care for the poor. These included encouragement provided by health care workers to clients perceived to be poor to register on the National Health Insurance Scheme. This was considered a way of increasing financial access to health services for the poor. Outreach services were conducted to reach those who were far from health facilities and hence, had to pay for transportation to receive health services. By taking the services closer to these clients, the health care workers considered that the transportation costs had been reduced and consequently, the health services were more accessible to the less wealthy clients. A community health nurse described this engagement with the community in the following way:

> *"So, we do visit those in the communities. And also even at times, those who don't have the money to purchase these drugs or 'this thing'…we encourage them to do health insurance. And there were instances that we tried to lobby and get health insurance for those who are vulnerable, those who cannot afford it. So, we do visit them. And also, we do inspections. Community health nurses go for home visiting to identify… to give them total care and if possible, we advise the children." (IDI-CH-MF-02).*

In addition to encouraging the enrolment for health insurance and the provision of outreach services, there were also health services provided free of charge to clients at the point of delivery. Some of these services were reimbursed by a non-Governmental Organisation working in the districts for clients registered by it. There were also situations where clients or children considered to be poor were given drugs for free at the discretion of the health staff, for instance, when children were considered very sick or for services such as family planning. This was done in the absence of a clear policy guideline, thus relying on the discretion of the health providers. A health care provider at the district level described support they had provided in the past for the poor even beyond the health needs of the clients:

> *"….well for the programme initially what we do was the very, very poor because it was a programme and there were funds for it. The little funds that we had for our volunteers, if we had people who were very poor, we could give them something small in order to start trading with ……"(IDI-DS-MF-02).*

The findings do indicate that at the lower levels of implementation, the actors applied a number of strategies they perceived could enable the poor access care or health services, thus demonstrating their preparedness and support for them. Key amongst these were increasing financial and geographic access through encouraging registration for the health insurance and providing outreach services, respectively. Their perceived role in addressing health inequities, therefore, seemed to focus mainly on addressing the financial and geographic barriers. Whilst the evidence on these barriers is well documented (Wagstaff et al., 2004), there are others, such as attitudinal and stigmatisation (Bloch et al., 2011), which were not considered. Strategies to address health inequities would need to recognise and address these beyond the classic barriers to health for the poor.

4.4.2 Awareness of National Policies and Strategies addressing health care for the poor

Having elucidated the perspectives of the stakeholders on health inequities generally in the preceding section, this next few paragraphs focus specifically on the awareness of the national strategies for addressing the health care needs of the poor. According to Buse (2008), the

actors' perceptions of the solution to the problem are crucial in the policy process (Buse, 2008) and hence, these focus here on their knowledge of national policies and strategies for addressing health care for this cohort. This was explored at national, regional and district levels. There was awareness almost all the stakeholders eleven out of the twelve interviewed at all the national, regional and district levels of the strategies being implemented by government to address health care for the poor, as shown in table 4-2 below. This table summarises the views of the stakeholders on the pro-poor strategies.

Table 4-2: Regional and districts actors' awareness of the solutions for addressing the health care of the poor.

		Number of respondents at the Different Levels	
Perspectives of poverty and equity (mentioned in the interviews) (Number of targeted respondents – 12)	**Number of targeted respondents (12)**	**National (No-5)**	**Regional and district (No-7)**
Mention of specific pro-poor policies and strategies	11	5	6
Health Insurance	5	3	2
Nutrition related interventions including CGP	5	2	3
Community Health Planning Services (CHPS)	5	3	2
Provision of free maternal and child health services	2	1	1
Provision of free services for specific diseases such as TB and	2	0	2
Social interventions - LEAP	1	1	0

Source: Researcher's fieldwork data

There were a number of strategies identified by the participants as addressing the health care of the poor (pro-poor). Health strategies and policies were considered pro-poor, if they increased financial access to health services, were community based and thus, provided services close to clients, targeted hard to reach areas or deprived districts, provided services

focusing on the vulnerable, such as the malnourished and/or were provided free of payment to the client. The more common interventions mentioned, by just under half of the participants, were the National Health Insurance Scheme (NHIS), nutrition related interventions, including CGP and the Community Health Planning Services (CHPS). The NHIS was viewed as the means to ensure financial access for the poor at both the national and district levels. Regarding the former, the emphasis seemed to be on addressing broadly the pro-poor agenda. As was put by one interview respondent at the national level: *"… The whole subject of the National Health Insurance system was a kind of pro-poor agenda that we needed to get people free access to health..., access to health services through that kind of arrangement*" (IDI-NA-05). The perspective at the district level, however, was focused more on patients accessing health care described by a district level manager as follows: "…. *an example is the National Health Insurance Scheme that helps them to come to the hospital all the time*" (IDI-DS-GE-02). This slightly differing emphasis at the national and district levels, is not surprising considering the roles and positions. Whilst the National actors were more likely to be concerned with the overall health outcomes, the district and community actors, who had more contact with clients, would be expected to be more concerned with their ability to access care. The existence of these differing perspectives could be of use in communicating and advocating for interventions in health care for the poor, at the different levels, so as to ensure the message is adapted to suit the concerns and interests throughout the system.

Another of the common interventions, mentioned by just under half (five out of twelve) of the participants interviewed at the national, regional and district levels, was the set of nutrition related interventions, including CGP. The actors' responses may have been influenced by the subject of the interview, which was focused on this programme; however, it is still significant that it was considered part of the solution to addressing health care for the poor. Malnutrition was considered a problem more amongst the poor and vulnerable and hence, the interventions to improve the nutritional status were more likely to target the poor. According to a national level participant: *"….we virtually target the vulnerable groups and … they turn out to be poor. So, most of our interventions target the poor, you know; the malnourished, you find mostly in*

the lower wealth quintals, mostly in the rural areas, in the underserved communities, the deprived communities" (IDI-NA-04).

The other most commonly mentioned intervention was the Community Health Planning Services (CHPS) - a community-based programme for getting services closer to the client. This was considered to help in improving geographic access to health care for the poor. A district health manager described the support provided by the CHPS programme in the following way:

> *"That place is very far and therefore one will walk for like two hours before getting to this place you understand, but today we have the CHPS zone there. so instead of walking to this place for just para (paracetamol) or antibiotic and then walk back, those there have these things and if possible, when the condition is too much they do call the NO (nursing officer) here and describe the condition to her and maybe she will tell them to go and come tomorrow ……. the CHPS zone is really helping, because the villages at a long distance also get access to health care." (IDI-DS-GE-02)*

These commonly mentioned interventions give an indication of the stakeholders' perspective of the importance of financial and geographic barriers to accessing health care. In addition to the commonly mentioned interventions, the provision of free services for certain demographic groups, such as pregnant women, children for immunisation and growth promotion services along with treatment of diseases, such as tuberculosis, were thought to be of benefit to the poor. Mention was also made of the social interventions implemented by another sector other than health. The fact that almost all of the study respondents, at the national, regional and district levels knew of policies and strategies to address health care for the poor, indicates that it was not a new concept, and thus could be built upon.

4.4.3 Relevance of the Pro-poor policies and strategies

The pro-poor policies and strategies were considered relevant and beneficial by nine out of twelve of the participants, as summarised in table 4-3. Whilst there was consensus on the relevance of these strategies at the national level, fewer participants at the regional and district

levels considered them to be salient. At the national level, the pro-poor policies and strategies were considered of particular importance for achieving health outcomes - increasing the coverage of interventions in the population and contributing to the achievement of national goals and targets, as expressed by one national participant: *"Ooh...., definitely it improves access, it means all of them get access to essential healthcare; it improves survival and therefore, ultimately it improves our coverage and outcome indicators" (IDI-NA-02).* Other health outcomes mentioned were the breaking of the intergeneration cycle of disease and ill health, if interventions were well implemented to address malnutrition in vulnerable groups. The fact that numbers of respondents mentioned the perceived relevance of the strategies at the regional and district levels, could be an indication of the lack of understanding of pro-poor strategies at those levels. Considering the priority of the pro-poor agenda at the national level, the high levels of understanding was to be expected. A summary of the perspectives is shown in Table 4-3.

Table 4-3: Actors' perceptions of the relevance of solutions for addressing health care for the poor

		Percentage of respondents at the different Levels	
Perspectives on poverty and equity (mentioned in the interviews) (Number of targeted respondents – 12)	**Total number of respondents**	**National level (No-5)**	**Regional and district level (No-7)**
Perceived relevance, application and benefits of national policies on poverty: For specific areas	9	5	4
Achieving health outcomes	7	5	2
Increase in access	4	2	2
Service delivery	3	1	2
Community participation	2	1	1
Planning	1	1	0
Resource allocation,	1	1	0
Prioritisation of poor who need care	1	1	0
Universal coverage	1	1	0

Source: Author's fieldwork data

Additional perceived benefits of the pro-poor strategies were the provision of services to the poor, particularly in hard to reach areas, increased access to services, provision of free health care to the clients and increased utilisation of services. These pro-poor policies were also thought to be critical for addressing the health inequities observed in the national statistics as well as for influencing planning and resource allocation. The implementation of these strategies, where community based, also enhanced community participation in the service delivery. The fact that nine out of twelve of the actors considered the pro-poor strategies relevant is an indication of the acceptance of their legitimacy. This acceptance of the pro-poor strategies by health providers is in line with the findings by Scott et al. (2012).

4.4.4 Challenges in implementing pro-poor policies and strategies

Despite the broad acceptance of the benefits of the pro-poor strategies, some participants involved in management at the national and district levels, did express a sense of frustration, pointed to the limitations and spoke of a sense of powerlessness regarding the implementation of these strategies. This was expressed by a national level policy maker as follows:

> *"We just hoped that having more resources would address (health inequities), but the evidence is that, that doesn't happen. We all know how resources have gone into certain areas and they are still not meeting the expectations. So, it is quite difficult. But it requires more direct intervention in terms of intervening in how services are delivered, which is beyond our scope within our department…..it is more to the regions and the districts, because we would think that we have given you enough resources and we would expect that you would move it to the areas concerned; but sometimes it is just not enough". (IDI-NA-03)*

This demonstrates the difficulties faced in ensuring adequate resources were made available for implementing the pro-poor strategies. Whilst the intention and commitment to addressing poverty was high at the national level, the actual implementation was dependent on the regional and the district health management. The national level interview respondents expressed the view that despite making sure that equity was a national priority, there were challenges in implementation that were beyond their control. There was also a challenge from the national perspective in guaranteeing adequate human resources for addressing health inequities. A national level policy-maker expressed the difficulty and the frustration of the sector in getting health staff to deprived areas to provide the required health services in the following way:

> "*One is trying to get a balance of the health staff, of the core health staff as I mentioned. So, how do we get especially doctors, nurses, midwives, to the deprived areas, because they are all centred in the urban areas? Sometimes you get about one or two midwives in a whole district and you could see that it is a big challenge."* (IDI-NA-03)

There were also challenges in implementing pro-poor strategies at the district level. The District Health Directorate members were of the view that the resources were held by the District Assembly and they did not adequately prioritise and allocate funds to the health strategies to address poverty. This was addressed in the following way by a district manager: *"When you go to the assembly, it is not their priority so you have to keep fighting every day for everything you get, but then we are making some progress*" *(IDI-DS-MF-02)*. Hence, there was this feeling by the stakeholders at each of these levels, that the power to address the issues of poverty lay in the hands of the next level. This sense of limitation and powerlessness may be due in part to the degree of decentralisation in the health sector as well as local government. These feelings of disempowerment exhibited by the health providers are at variance with documented patterns of resistance and opposition demonstrated by actors whose values or interests affected by the policy (Gilson & Raphaely, 2008), but do align with the findings of Scott et al. (2012), who suggest that a broader perspective of influences should be explored to explain the response of actors to the policy implementation.

4.5. Conclusion

The policy process is influenced by actors' "….position in power structures, their own values and expectations." (Walt & Gilson, 1994, p. 355) It is therefore critical to understand the differing values, beliefs and expectations of the actors in the policy process by assessing the policy retrospectively, as well as investigating prospective policy engagement strategies (Buse, 2008). The findings from this chapter have provided some insight into the formulation and implementation actors' perspectives on poverty, health and inequity as well as their perceived roles and abilities in affecting the policy process. These findings contribute to the existing body of knowledge on the perspectives of health providers in the policy implementation process.

The findings have shown a majority – two-thirds of the participants interviewed - recognised the need to pay attention to health care for the poor. This recognition varied at the various

levels of the health care system, being highest at the national level, but less well understood at the district and community levels. There are different drivers that account for this variation. At the national level, the stakeholders were influenced more by the broader issues, such as national priorities, whereas at the district and community levels, they were influenced more by their observations of the difficulty clients were having in accessing services on account of poverty. The interplay of these drivers do account for the differences in the perspectives on poverty at the different levels. It is therefore important to understand these drivers and provide effective communication of national policy issues and priorities to ensure alignment with national objectives at all levels of the health system (McIntyre & Klugman, 2003).

The findings have shown that whilst most national and district participants believed the national pro-poor strategies were of relevance, there was a feeling expressed by some that they were powerless to implement these strategies owing to the limited resources. This finding corroborates with that from another study by Scott et al. (2012) that whilst the actors broadly accept the goals of equity, there are factors that influence their implementation of these policies. Therefore, rather than focusing on the implementation actors and seeing them as mainly offering resistance, more research should be undertaken to understand their perspectives and this information should be utilised to improve their responses equity issues (Buse, 2008). Whilst similar studies to the current one have been conducted (Scott et al., 2012) to understand the perspectives of implementing actors, the fact that this one was carried out in a different setting, as well as with community level actors, does contribute to the literature, in particular with evidence regarding the understanding of the perspectives of health providers.

5. An analysis of equity issues in the Community Growth Promotion (CGP) programme in Ghana

5.1: Introduction

In this chapter, the findings from the documentary analysis, in-depth interviews and focus group discussions relating to the initiation and implementation of community growth promotion services are presented. The aim is to identify the factors leading to the initiation of community growth promotion, to understand the perspectives of the stakeholders, and obtain some insight into their experience in community growth promotion. The chapter begins with an overview of the empirical basis of the analysis, which is followed by an analysis of documents and the components of the thinking and understanding of issues relating to the initiation and implementation of community growth promotion. This draws upon quotations from the interviews and shows commonalities and variations in the accounts of the recipients. In this chapter, the following research questions are addressed:

- How is community growth promotion (CGP) structured and delivered to reach the poor?
- How do health workers and volunteers at all tiers in the health system integrate equity issues in the planning and implementing CGP?

5.2 Empirical Basis

The empirical basis for this chapter is influenced by a number of frameworks and theories commonly utilised in the policy process. As discussed in the methodology section, this study is guided by the policy triangle framework, which structures the policy process into content, context, process and actors (Walt & Gilson, 1994). In the preceding chapter, the focus was mainly on the actors, whilst in this chapter the purpose is to analyse the processes of initiating and implementing community growth promotion at scale and the context in which this was done. Whilst this framework model defines these four distinct components for policy analysis, in reality they do not function as such. There are interactions within all components – for

example the actors may influence the process, the context may influence the actors and the like. Another key policy framework underpinning the analysis in this chapter is the stages heuristic framework (Walt et al., 2008). This framework has been described earlier in the methodology chapter and divides the public policy process into four stages: agenda setting, formulation, implementation and evaluation. Even though this framework has been criticised for being unrealistic and not effectively addressing the causal elements (Hupe & Hill, 2006), it does provide a simplified approach that enables the study of the policy process in a systematic way. In this chapter, the stages heuristic framework is utilised to guide the overall structure of the analysis. In order to address the research questions, I present the analysis according to the agenda setting, formulation as well as the implementation and evaluation stages. At each of the stages, the findings are analysed to identify issues relating to the structuring and delivery of health services to the poor as well as how the actors integrate issues of equity in these stages.

The stages heuristic framework is complemented by other policy analysis theories– multiple streams and the implementation theories - to enable more depth in the understanding (Walt, Shiffman, Schneider, Murray, Brugha, & Gilson, 2008). The multiple streams theory is focused on the agenda-setting stage of the policy process, under which is proposed that this phase has independent steams of problems, policies and politics that come together within a window of opportunity to lead to an action (Kingdon, 1984 as cited by Walt et al., 2008). This theory has universal applicability and has been utilised in studies in several jurisdictions at international, national and subnational levels (Cairney & Jones, 2016). The strength of this theory is its simplicity, thus enabling its use by non-specialists as well it having ability to "explain a large part of the policy process" (Cairney & Jones, 2016, p. 40). In sum, the multiple streams theory is employed in the analysis of this chapter to identify the extent to which issues of health care for the poor and equity have influenced the agenda setting stage of community growth promotion. Beyond the agenda setting, the next stages in the policy process, formulation, implementation and evaluation are analysed through utilisation of the implementation theories (Walt et al., 2008; Sabatier, 1986). The literature on implementation theories proposes the top-down approach, the bottom-up approach and a synthesis of the two (Hill & Hupe, 2002). In the top-

down approach, the focus is on the policy decision-making at the central level and the extent to which its objectives are met over a particular period. The key questions under this approach to analysis are:

1. To what extent were the actions of the implementing officials and target groups consistent with that policy decision?
2. To what extent were the objectives attained over time, i.e. to what extent were the impacts consistent with the objectives?
3. What were the principal factors affecting policy outputs and impacts, both those relevant to the official policy as well as other politically significant ones?
4. How was the policy reformulated over time on the basis of experience? (Sabatier, 1986, pp. 22-23)

The bottom-up approach to the contrary, focuses on the network of actors involved in the policy implementation at the local levels and their influence in the policy process through their interpretation of the goals and the decisions they take in relation to implementation. There are strengths and weakness of each of the approaches and the choice of one or the other is determined by the perspective of the researcher. In this chapter, the top-down approach is deemed expedient as "there is a dominant public program in the policy area under consideration" (Sabatier, 1986, p. 36) and the research is focused on "the extent to which the whole system is structured/constrained" (Sabatier, 1986, pp. 36-37).

The utilisation of a number of policy analysis frameworks and theories from the literature is consistent with other studies (Koduah et al., 2015). In the referenced study, the authors drew on the policy analysis theories of Grindle and Thomas (1991) as cited by Koduah et al., (2015), Kingdon (1984), as cited by Koduah et al., (2015), Gilson (2008) and Mintzberg (1983) as cited by Koduah et al., (2015) to conceptualise context, policy actors and power in their analysis to reconstruct agenda setting and policy formulation events. Likewise in this analysis, I draw upon the Kingdon's multiple streams theory (Kingdon, 1984) as cited by Walt et al. (2008), Sabatier's implementation theory (Sabatier, 1986) as well as the overarching stages heuristic framework

(Walt et al., 2008). Drawing on these frameworks and theories, this chapter presents findings structured according to the stages of agenda setting, formulation, implementation and evaluation, with the detailed analysis in each section guided by the theories discussed.

5.3 Findings

5.3.1 Agenda Setting

There were a number of factors that influenced the process whereby CGP was transformed from a pilot programme to a national priority programme. Drawing on Kingdon's multiple streams theory (Cairney & Jones, 2016), I explain how the problem, policy and political streams came together in a window of opportunity that resulted in the initiation of the national programme, according to a review of national documents and data from the interviews. The extent to which issues of poverty and inequity influenced the agenda-setting is reflected in the analysis.

The problem stream was driven by the high prevalence of malnutrition in children, with 30% of children below the age of five years stunted, 22% of them under-weight and 76% anaemic (Ghana Statistical Service (GSS); Noguchi Memorial Institute for Medical Research (NMIMR); ORC Macro, 2004). This high prevalence was of key concern as it was associated with high rates of child mortality and loss of productivity (World Bank , 2007). The level of concern is reflected in the descriptions of the problem in national documents: The Concept Note on *Imagine Ghana Free from Malnutrition* describes malnutrition as a "major public health and developmental challenge in Ghana" (Ghana Health Service, 2004, p. 1), whilst "persistent under-nutrition" as being one of the challenges facing the health sector was highlighted in the Ministry of Health's Five Year Programme of Work 2007-2011 (Ministry of Health, 2007). One of the national stakeholders further explained the government's concern with the possibility of the country not achieving Millennium Development Goal 1 (MDG) on account of the prevailing high malnutrition rates at the time: *"there were concerns that we may not be able to meet the*

MDG 1 for nutrition, and therefore..., malnutrition... and therefore there was the need to do something" (IDI-NA-03). Whilst issues of poverty and inequity were not observed as direct drivers of the problem stream, they indirectly influenced the process. According to national documents there is evidence that malnutrition and poverty act in a downward spiral, whereby each exacerbates the other (Ghana Health Service, 2004), (Minstry of Health, Ghana, 2007). The available data from Ghana and elsewhere are evidence of the high rates of malnutrition among the poor (Fotso, 2006). In sum, given the linkage between poverty and malnutrition the agenda pursued through CGP that was aimed at the influencing the latter also positively impacted on the former.

Linked closely to the identification of malnutrition as a problem, came the attention and prioritisation of the issue of nutrition - the political stream. The publication of the Concept Note, *Imagine Ghana Free from Malnutrition*, by the Office of the Director General of the Ghana Health Service indicates the high level attention given to the issue of malnutrition. The Ministry of Health, Ghana in its *National Health Policy: Creating Wealth through Health* (Minstry of Health, Ghana, 2007) announced a number of shifts in the paradigm for health development, which included *"Health promotion and ensure that people remain healthy and stay out of hospitals*" (Minstry of Health, Ghana, 2007, p. 32), thus indicating the shift in focus from a disease based approach to a more preventive focus that included nutrition. These changes raised the profile of nutrition and placed it high on the national agenda with substantial political attention being directed towards the matter.

There were a number of factors in favour of the scaling up community growth promotion (CGP) as the programme of choice to address the problem of malnutrition. To begin with, CGP had been implemented in the country on a pilot basis and hence, a number of the technical programme officers had prior knowledge or involvement of the programme. A number of these programme officers working in the Family Health Division of the Ghana Health Service, the arm responsible for Nutrition Programming, were given the mandate of developing the proposal. This division of the Ghana Health Service thus considered CGP to be a sound option

for addressing the issue of malnutrition. This was because it had improved access and participation of the community and had worked, as one of the National level participants put it: "*after about four years of implementation we actually saw that it (Community Growth Promotion) worked" (IDI-NA-02)*. Another factor in favour of this option was its inclusion in national documents as one of the strategies to address malnutrition (Ghana Health Service, 2004).

The three streams – problem, policy and political integrated with the "window of opportunity" that manifested itself as the availability of funds in the form of a loan from the World Bank (World Bank , 2007). The Project Appraisal document recognised the prevailing high rates of malnutrition at the time, the public health burden, the linkages with the Millennium Development Goals as well as the strong focus the country had placed on addressing malnutrition in various policy documents (Ghana Health Service, 2004) (Minstry of Health, Ghana, 2007).

5.3.2 Formulation of the CGP programme

In the policy process, the formulation stage refers to the design and enactment of policies by the decision makers and other actors (Walt, et al., 2008). Consequently, the formulation of CGP was influenced by these existing processes and the players involved. A key aspect of the programme formulation is the setting of objectives. The Project Development Objective was to "improve utilization of selected community based health and nutrition services for children under the age of two and pregnant women in the selected districts" (World Bank, 2007). These objectives were expected to be achieved through strengthening institutional capacity and increasing demand for as well as expanding community based services. The actors at the national level, who were involved in the formulation stage, also mentioned these key objectives with no direct reference to reaching the poor. Although not stated as a clear objective of targeting the poor, community based strategies have been utilised in various settings to increase the uptake of interventions, particularly amongst the poor (Callaghan-Koru, et al.,

2013; Findley et al., 2006) and hence, the objectives of the project were consistent with approaches aimed at addressing health equity gaps. The proposed solution of scaling up CGP was structured to prioritise regions with a high burden of malnutrition (World Bank , 2007). As has been established, these regions were associated with high prevalence of poverty and thus, the programme by prioritising these regions did contribute to addressing inequities, by providing more care for those with greater need. This prioritisation of services for the deprived communities also came into play at the regional and district level; as one district level actor observed: *"If the community is a very deprived community, or hard to reach area, you must choose that community*" (IDI-DS-GE-01). This implies that there was some integration of equity issues in planning CGP by the health workers at the district level.

5.3.3 Implementation

The implementation in the heuristic stages framework refers to the carrying out of the policies or programmes by government and implementing actors (Walt et al., 2008). There are a number of factors influencing implementation. Drawing upon the top-bottom implementation theory, this subsection focuses on the actions of the stakeholders implementing the policy decision; the attainment of the objectives; the factors affecting programme outputs; and to a lesser extent, how the programme was reformulated over time. The extent to which issues of poverty and inequity influenced the implementation is reflected in the analysis.

5.3.3.1 Actions of the stakeholders in implementing the policy decision

CGP was implemented more in line with the top-down approach of implementation (Sabatier, 1986), with more involvement in the decision-making at the national level than at the district and community levels. At the national level, it was perceived as a means of primary health care delivery at the community level, an entry point to promote optimal feeding and an effort to improve access and strengthen community participation, with the opportunity being presented, as aforementioned, by the availability of funds from the World Bank. In describing the process

leading to implementation, a director from the Ghana Health Service (national level) stated that the proposal was developed at the National level in contact with other levels. He reported that it was formulated in response to the opportunity for the funds from a World Bank Loan, which was approved and led to the implementation of CGP on a larger scale. In accordance with the policy decision to scale up, the implementation was pursued through the cascade model of training, whereby the national, regional and district levels were used as layers of training to pass on the knowledge and skills to the final target group at the sub-district and community level. Whilst this model allows for a large number of people to be trained, it also can lead to a high level of dilution and thus, quality could be lost from one level to another. The cascade model of training is commonly used in Ghana in the scaling up of intervention programmes (Bergh et al., 2012). In accordance with this top-down approach of cascading training, those at the community and district levels were of the view that the programme was initiated from a higher level and brought to their respective levels. This perception was stated factually and not presented negatively or with resentment by the participants as has been found in other studies (McIntyre & Klugman, 2003). Indeed some participants rationalised the relevance of the programme in terms of strengthening community participation, improving the health of mothers and children and addressing the needs of the poor. This acceptance of programming from the higher level could be due to the established system of governance within the health sector in the country which is hierarchical (Koduah, et al., 2015). Another factor that may have influenced the acceptance of the programme from the higher level may be the fact that the Central Region had piloted CGP in one of its districts and hence, there was some knowledge of the programme amongst the stakeholders. The actions of the implementation actors, in cascading the training at all levels, were in line with the decision to scale up the implementation of the programme.

The actions of the actors evolved further beyond the cascade training, as the actual project implementation stared. These actions were based on their roles and responsibilities in the delivery of CGP and general health services. The community health nurses considered their role as providing their services, such as monitoring the growth of children from birth to five years, to

ensure that children were growing well. As community health workers, they considered themselves "front liners of the government's policies at the community base level" (IDI-CH-MF-02). In this regard, they visited communities and provided services for those who were close as well those who were distant at their facilities and at outreach services respectively. They also provided health education, conducted home visits, performed contract and defaulter tracing as well as visiting the poor and aged. Moreover, the community health workers were responsible for training the volunteers and supervising their work. The responses of the community health nurses do give an indication of their consideration of equity issues in their work. The planning and delivery of outreach services for communities located far from the facilities is one of the ways of addressing geographic barriers, which are faced mainly by the poor. In addition, the mentioning of the poor as one of their target groups for care is also an indication of the measure of integration of equity into their work. The community health nurses have been used by the Ministry of Health as the cadres to get services closer to the community and to increase access. Their integration of equity issues in their work is therefore in line with the intended government strategy of increasing access to health care.

In addition to the community health nurses, the volunteers were another key group of actors involved in implementing CGP. These volunteers worked in the community, in collaboration with the community health nurses, to provide a range of services. These included organisation of logistics for the community growth sessions, mobilisation of the community, monitoring the growth of children and counselling their caregivers, educating the community on health issues and home visits. The volunteers considered they were complementary to the established or formal health system and accountable to both the health system and the community. They took pride in their role and saw themselves as being appreciated by the communities in which they lived and worked, thus having the trust of the people. They did consider that their role was somewhat sacrificial as it impacted negatively on their day jobs during some seasons. They, therefore not surprisingly, experienced strong emotions, in particular anger, against those who did not appreciate their work. Whilst the volunteers did not consciously express a focus on the

poor and addressing equity issues, this was likely to be covered in their role of following up of non-attendants and defaulters of CGP, who were most likely to be the poor and marginalised.

5.3.3.2 Attainment of the Objectives

Drawing on the top-bottom approach, the next area of analysis in the implementation, following the actions of the implementing stakeholders, is the extent of the attainment of the objectives. This was assessed by considering the set objectives of the programme and whether these had been met through the programme. The main objective of the programme was "to improve utilization of selected community based health and nutrition services for children under the age of two and pregnant women in the selected districts" (World Bank, 2007). This required the setting up of structures and systems for the delivery of the services, the provision of the services and the utilisation by the target groups. In line with the objectives, the CGP services were targeted mainly at children, particularly those aged between 0 -2 years of age and pregnant women. These children and women were registered and followed up regularly by the community volunteers. There were monthly growth promotions sessions in the community for the targeted groups and the volunteers informed the community members and mobilised them to utilise these health services. They also conducted home visits and traced defaulters who were not coming for monthly growth monitoring sessions, thereby ensuring that all the children were reached by the services. Considering the barriers faced by the poor in accessing health services (Wagstaff, 2002), this approach of providing services close to the community and following up those not utilising the services is likely to help in improving the uptake for the poor. The services provided at the sessions included weighing of the children and monitoring their growth on a monthly basis, providing feeding counselling specific for the child's age and growth trend, immunisation, health education, and identification and referral of sick children for care in the facilities. The volunteers provided health education on disease prevention, such as the use of bed nets to prevent malaria as well as hygiene and sanitation, including the use of clean water. The focus of the programme on nutrition, communicable disease prevention along with hygiene and sanitation is in line with addressing equity, as the conditions of malnutrition

as well as poor hygiene and sanitation and communicable diseases are higher amongst the poor.

There were several benefits of the programme that were expressed by the participants. The caregivers were of the view that the services were closer and hence, they did not require transport to get there; they only needed to walk to obtain access to the services. Services, they reported, were provided more frequently in the community and therefore it enabled them to check on the health of the child more regularly. The health providers they said also took care of pregnant women and advised them so they would have healthy children. They believed by taking the child regularly for growth promotion and the other services, such as vaccination, this prevented the child from falling ill and made them healthy. They were of the view that many community members – the rich as well as the poor – were benefitting from the services.

The community leaders were of the view that the programme had several benefits, as expressed by one of them: *"it helps the caregivers and also it helps the children as well"* (IDI-CL-GE-01). The community leader explained that the programme educated them on appropriate infant feeding practices, which enabled the child grow and develop as well as protecting the child. Also, by having a healthy child, the caregiver was saved from hospital visits and the attendant costs. Other benefits expressed were the fact that the services were closer to the community, better organised, such that caregivers were more aware of the timing and could plan for it and had spread widely and thus, increased their utilisation. The community volunteers were also of the view that the programme had increased usage of the services. They also recognised the benefits of the programme when they saw improvement in the growth of the children in their work. The community health nurses also saw the benefits, highlighting the growth of children, better follow up of pregnant women, increased utilisation and generally improved delivery of health services. At the district level, some of the benefits indicated were the delivery of services close to clients, reaching the poor and deprived communities along with improving the health and growth of children in the community. Two of the participants reported they had benefitted professionally from the programme through increased knowledge

of growth promotion and better understanding of the community. Whilst the programme objective was to primarily increase utilisation of services, the perception amongst the stakeholders was that much more than this had been achieved. The programme had tangible and intangible benefits to the direct beneficiaries, the implementing actors and the poor and deprived communities.

5.3.3.3 Principal factors affecting policy outputs and impacts

Drawing on the top-bottom approach, the third area of analysis in implementation following the actions of the stakeholders and the attainment of objectives, is the principal factors affecting the policy outputs and impacts. This section of the analysis thus focuses on the perceptions of the key stakeholders – both beneficiaries and implementers of programme – regarding the immediate factors affecting the utilisation of the services as well as issues of sustainability.

Perception of the services provided

There was generally a positive impression of the services amongst the community participants. Regarding the community leaders, they thought the programme was doing well and generally widespread and accepted in the community. One community leader described the caregivers' perspective of the programme as such:

> "*Most of the nursing mothers have testified of its goodness, those who have given birth to two or three. Someone said my first child I gave her water when she wasn't six months old, I gave her water and food but for the second one when I was told not to give her water and food. Comparing the two children I realise that* the *second one is very intelligent. When you listen to the child speak and her approach to things you realise that she is smarter than the other one" (IDI-CL-GE-01).*

This positive view of the programme is likely to be due to the strengthened component of feeding counselling and the resultant improvement in the knowledge and practices of the

caregivers. CGP has been associated with improved breastfeeding in the communities in which it is implemented (Alderman, 2007). These improved breastfeeding practices are particularly beneficial amongst the poor, as breastmilk remains a key component of the nutrient component of the child up to two years old. These positive perceptions were reiterated by the caregivers in the focus group discussions.

In addition to the perceived benefits of improved infant feeding knowledge and practices, the caregivers were appreciative of other aspects of the programme. They reported that the community volunteers had improved the interaction and relationship between the caregivers and the nurses, and the programme helped caregivers take their children for growth promotion. The volunteers made announcements about the timing of the services and organised the caregivers into groups in order to spread out the attendance over the month, both of which helped attendance. The programme also enabled them to check the health of their children frequently and intervene when something was not right in the child's body. The caregivers were also of the view that the nurses were helpful and provided services for those who attended the sessions as well as educating them on hygiene and disease prevention. The community health nurses said that their interpersonal relationship with the caregivers and community members had improved as result of the programme. This generally positive perspective regarding the services by the community members is likely to be due to the closer interaction and engagement with the health system provided as a result of the interface with the community volunteers. These positive perceptions on both the side of the providers as well as the users' side are mutually reinforcing and are likely to build trust and bridge the gap that may still persist between the two.

In addition to these positive perceptions of enhanced infant feeding and improved caregiver-health provider linkages, there was also the perception that the programme catered for the needs of all. The caregivers in the focus group discussions indicated that the service was for everyone no matter your status, rich or poor. They did report that the volunteers went from house to house and even those at home did benefit from the services, even in situations where

they did not have money. To further underscore the fact that the service was for everyone, a caregiver mentioned "*Every nursing mother is looked at no matter your dress*….."(R3: FGD-GE-02). This does imply that the caregivers felt the health providers did not discriminate against mothers or caregivers on account of what they were wearing. This is of note as the mothers' clothing has been found to be a key deterrent to attending health care services for children (Bosu et al., 1997). In Ghana, women who have delivered babies are expected by the culture and society to wear certain relatively expensive outfits for a period of six months to a year after delivery, whenever they go on an outing. Child welfare sessions are considered as outings and hence, caregivers feel they are obliged to wear these outfits whenever they attend a session. Consequently, those who do not have adequate numbers of outfits are likely absent to themselves from the services. The fact that the caregivers felt that they could wear any outfit for the service is an important measure of the accessibility and openness of the services, particularly for the poor, who may have challenges in relation to expensive outfits.

Despite these positive perspectives, there were some negative ones, as described by one caregiver in an in-depth interview: "*When you go for weighing and you are late they won't serve you, they even insult you in front of everybody when it happens that way then you become very shy*" (Case Narrative). This negative attitude of health workers in the form of verbal abuse workers is not uncommon in the health sector in Ghana and other countries (Bannerman et al., 2010; Mannava et al., 2015). This is of concern as it is likely to affect the utilisation of health services, particularly amongst the poor and marginalised. In a study carried out in three regions in Ghana, it was found that health workers were likely to be more unfriendly to the less educated, farmers and those working in the informal sector (Amporfu, et al., 3013).

<u>Immediate Factors affecting Utilisation of Services</u>

One of the key objectives of the programme was to increase utilisation of community and nutrition based services amongst caregivers of children under two years and pregnant women. There were a number of factors expressed by the caregivers that affected their usage. When

services delivery times coincided with income generating activities, this, caregivers said, affected the utilisation of services. For others, the lack of funds was a deterrent, as they were concerned that they might be expected to make payments for various services, such as medicines or cards for their children and hence, that prevented them from seeking services. These barriers to the utilisation of the services, as expressed by the caregivers, are particularly serious for the poor and vulnerable (Ensor & Cooper, 2004). Despite the services being supposed to be provided free of charge at the point of delivery, various out of pocket payments had been introduced, thus creating direct costs to the caregivers, which were likely to affect especially the poor. Also, the challenge with the service delivery times clashing with income generating activities created an opportunity cost for the caregiver, as the potential income for the day could be lost on account of attending the services. These thus constitute direct and indirect costs to the caregivers, which could be significant for the poor.

Beyond the costs to the caregivers, other factors affecting utilisation were inadequate notice of service delivery sessions and pressure on the part of caregivers with regards to their appearance and that of their children. These reasons proffered by the caregivers are not surprising as these are known factors that affect the take up of health services - particularly child health services in Ghana (Bosu et al., 1997). With regards to inadequate notice of services, the expectation was that the community volunteers would serve as the link between the formal health system and the community to reduce this. The fact that it still occurs is an indication of the weaknesses in the expected linkages. What is more interesting is the issue of dress, for although caregivers felt they were not discriminated by the health system on account of the clothes they wore, it still created some tensions amongst them. Caregivers indicated that the mothers compared their dressing and the children's clothes and this was a source of shame and pressure for some, which led to them not attending. Some caregivers reported that they preferred to attend sessions outside the community where they were relatively anonymous.

A number of factors mentioned by the caregivers were also raised by the community leaders, however, the perspectives differed. In terms of the dress, the community leaders felt it was a deterrent in the past when mothers had to attend services outside the community. However, within the community this was not supposed to be a problem. Secondly, with regard to payments made, they were of the view that there were no fees paid and even when they were required, the amounts were not significant and thus, should not be a deterrent. Also, concerning income generating activities, the community leaders contended that caregivers, who complained about market day clashing with community promotion activities, could always go to market on a different day. Thus, the commonly held view amongst the community leaders was that there were no major deterrents to utilisation of the services, as one community leader put it:

> "*To me I don't see anything blocking them (caregivers) from going for the service, because it is now part of their duties to take the children to weighing every time the nurses are in. So whatever they are doing, they must organise their schedules well so that nothing will block them, but sometimes they do some cooking and some washing and other things that may prevent them coming for weighing, but apart from that I don't think there should be other things to prevent them from coming*" (*IDI-CL-MF-01).*

This quote does reflect, to an extent, the societal and cultural views of the expectations of a mother in caring for her household. There is recognition of the numerous responsibilities the mother is expected to carry out, whilst also trying to make time to attend growth promotion services for the child's welfare. Secondly, the comment above does bring to the fore the differing worldviews that exist in the same communities based on the subjective experiences of the individuals. For the community leaders, who were mainly male, their lived experience with regards to CGP is likely to be confined to encouraging caregivers to utilise the services and community mobilisation efforts. The caregivers, however, as the end-users of the service were likely to have experienced monthly sessions with the attendant challenges of funding payments. These differing perspectives amongst the caregivers and the community leaders highlight the importance of exploring and understanding the perceptions and experiences of the different groups of stakeholders so as to inform programme action.

In addition to the financial, socioeconomic and cultural barriers indicated in the preceding paragraphs, other factors affecting utilisation were the existence of incentives and the quality of care received. A key factor affecting usage mentioned by one community leader was the food incentives given to the caregivers in the past by some programmes. This apparently was an inducement for mothers and hence, when this ceased some caregivers were not motivated to attend the sessions. The use of incentives, in particular financial incentives, to increase the uptake of public services in health and education has been applied in several countries (Fiszbein et al., 2009) with positive results. The challenge, however, as evidenced by this example from the community, is the issue of sustainability of these incentives, which could affect the health outcomes in the long term.

Other issues raised by the stakeholders that could affect the sustainability of the programme were the expansion of the roles of community volunteers and their retention as growth promoters. Community members suggested an expansion of the roles of the volunteers to include the management of minor ailments in children under-five, so as to obtain the maximum benefits from their services. Such a change, would enable them provide more services to the women. Another challenge affecting the sustainability of the programme was the phasing out of the allowances for the community volunteers. Even though their role was voluntary, community volunteers still had some expectation of reward and therefore, the allowances and other incentives given them were positive motivations for them. With the ending of the project, the funds were not readily available and hence, the volunteers were not as enthusiastic about providing services as they had been before. This was affecting the quality of the services provided and likely to influence their retention and the sustainability of the programme.

Whilst not being expressed, the level and detail of knowledge shown by the community leaders was remarkable. In explaining the benefits of the programme, one community leader said:

> *"It helps the caregivers in a way that if the child is not six months old and you are told not to give the child water, the doctors make us understand that with the breast milk*

seventy percent is water and thirty percent is food. So, when the child takes in the breast milk the child gets more water than food, so don't give the child water for six months that is what is going to help the child develop" (IDI-CL-GE-01).

Such knowledge and active engagement of a community leader on health issues is definitely of long term benefit to the community. Such a leader could serve as an advocate to motivate caregivers to utilise the health services and adopt healthy behaviours.

5.4 Conclusion

This chapter sought to examine the extent to which the CGP programme was structured to reach the poor and the extent to which the actors factored equity considerations in their implementation of it. Drawing upon the stages heuristic framework, the analysis was structured based on three stages of the policy process: agenda setting, formulation and implementation. The analysis involved drawing further upon theories of the policy process – the multiple streams theory as well as the implementation theories, and themes emerging from the data to guide the process. The findings from the analysis provide some insights into the ways in which issues of poverty and equity directly or indirectly influenced the agenda setting, formulation and implementation of community growth promotion, as well as the considerations of the actors in the process.

The main driver influencing the agenda-setting of the CGP programme was the high prevalence of malnutrition in the country and its consequent effects of the failure to achieve the national targets and loss of productivity. Even though the issues of poverty and inequity were not to the fore, they have indirectly influenced the national agenda on account of the strong association between poverty and malnutrition. Secondly, in relation to the formulation of the strategy, the selection of CGP – a community–based intervention - meant the services were closer to the clients, thereby eliminating transportation costs and increasing geographic access, which is usually a challenge for the poor. Thirdly, regarding the selection of the implementing regions, the regions with the highest prevalence of malnutrition, which also happened to be the regions

with higher rates of poverty, were prioritised. Through the process, the programme focused on increasing services to the poor and deprived communities in need of care. Thus, whilst issues of poverty and health inequity were not explicit on the agenda, they indirectly influenced the agenda setting and formulation of the strategy, such that it focused on addressing the needs of the poor.

At the level of implementation, there were varied observations regarding the extent to which the CGP programme was structured and functioned to address the needs of the poor. However, even though the proposed structure was aimed at increasing access by ensuring services were closer to the clients and focused on diseases and conditions associated with poverty, regarding its actual implementation, there were some barriers to achieving the outcomes. There was a generally positive perception of the programme amongst the caregivers and community leaders. However, the introduction of various fees associated with the CGP services and poor notice of service delivery time did serve as obstacles to accessing services for the caregiver. This demonstrates the variance between the proposed objectives, the actual implementation as well as the experience of the end-users and thus, highlights the importance of monitoring the implementation to ensure the delivery is in accordance with the set objectives. In sum, this study has therefore shown that whist the programme was structured to address the health care needs of the poor, this was not completely addressed in its delivery.

Further in relation to the structure and delivery of CGP, the study found differing degrees to which the health workers and volunteers integrated equity issues in planning and implementing it. When setting the agenda for CGP, there was indirect integration of equity issues by the policy makers and national stakeholders when aiming to tackle the burden of malnutrition owing to the previously reported linkage between the two. Also at the formulation stage, for the national level stakeholders, addressing the issues of poverty and equity were not the foremost considerations when planning CGP. However, in planning to increase access to care through community–based provision close to client services, for the regions with the highest burden of malnutrition, their decisions favoured the poor. At the district and community level,

health providers, particularly the community health nurses, were more considerate of poverty and equity issues in their work. This study has, therefore, shown that consideration of poverty and equity issues was more direct in terms of the district and community level health providers when planning and implementing CGP than at the national level.

6. Findings – Factors that influence the uptake of health interventions among the poor at community level

6.1: Introduction

In this chapter, the findings from the in-depth interviews and focus group discussions relating to the factors that influence the uptake of interventions among the poor at the community level are presented. The aim is to identify the issues and factors affecting the utilisation of the services amongst the poor, to understand the perspectives and to gain insights into the experiences of the caregivers and community members when accessing health services, particularly in relation to the poor. It also provides some perspectives of the health workers at all levels on the organisation and provision of health services to the poor and marginalised groups and the challenges in doing so. The chapter begins with an overview of the rationale underpinning the empirical analysis, which is followed by explanation of the components of the thinking and understanding regarding issues relating to the uptake of interventions at the community level by the poor. This draws upon quotations from the interviews and shows commonalities and variations in the accounts of the recipients. This chapter, therefore, seeks to address the third objective of the study, which is to shed light on the key issues that influence the uptake of interventions among the poor at the community level.

6.2 Empirical Rationale

The empirical rationale for this chapter is shaped by the overarching framework guiding this study, that is, the policy triangle framework, which structures the policy process into content, context, process and actors (Walt & Gilson, 1994). In the preceding chapters, the focus was on the actors, the content, the processes of initiating and implementing community growth promotion at scale and the context in which this was done. This chapter proceeds to analyse broader issues relating to access to health care for the poor from the perspective of the end-

users and beneficiaries of the services as well as providing understanding with regards to the context of the provision of health care services to the poor. The analysis is guided by the literature (Wagstaff, Bustreo, Bryce, & Claeson, 2004; Wagstaff A., 2002) as well as the thematic framework developed from the data using the framework approach (Pope, et al., 2000; Ritchie & Spencer, 1994).

Applying the conceptual framework for understanding health inequalities proposed by Wagstaff (2002); factors that affect the use of health services and other health practices, include household and community factors, health service provision and the availability of food, water, sanitation and infrastructure. These factors are, in turn, influenced by the health financing mechanisms as well as the overall government policies and actions in relation to health and other sectors. The author thus groups the determinants of health care outcomes into household/community factors, health system and related sectors and government policies and actions. Wagstaff et al. (2004) organises these determinants of socioeconomic inequalities in child health under financial barriers, health care provision, maternal education, water and sanitation and the home environment. Drawing upon these frameworks, this chapter seeks to identify the factors affecting the uptake of services amongst the poor and it is structured as follows:

- Household and community factors affecting the uptake of health services by the poor
- Health service provision and health system factors
- Health Policies and actions that influence the delivery and uptake of health services by the poor
- Addressing the health care needs of the poor

The section on the household and community factors analyses the availability of household assets mainly in the form of finance and how this influences and is affected by the utilisation of health services. The sociocultural influences drawn from the thematic framework are analysed under community factors affecting access to health care for the poor. The second section, which analyses the health service provision, addresses issues of ease in accessing the facilities,

the organisation of the health services, as well as the perceived quality of the services received. The third component of the analysis addresses the health system challenges in addressing the needs of the poor. The fourth component is focused on ways to improve care for the poor and includes a section on the perspectives regarding poverty at the community level. The final section in this chapter draws some conclusions on the findings from the chapter.

6.3 Findings and Discussion

6.3.1 Household and Community Factors affecting the demand for Health Care by the Poor

6.3.1.1 Financial Factors

At the household level, the availability of finances was one of the most crucial factors affecting the utilisation of health services. The import of available finances in accessing care is aptly captured in essence by a phrase provided by one of the participants, a community volunteer "*it is all about money*" (IDI-CV-GE-02). The fact that the payments required for health care is one of the key challenges affecting access to care in accordance with the literature (Wagstaff, 2002). These payments, referred to as out-of-pocket payments or user-fees, have been utilised by a number of countries in Africa, including Ghana, to fund health care costs (McIntyre et al., 2008). In Ghana, these fees, were introduced as part of the policy of cost sharing and were aimed at improving the quality and access to care (Badasu, 2004). These fees were, however, found to be a deterrent to accessing care amongst the poor and thus, negatively affected utilisation of health care. With the introduction of the cash and carry system to recover 100% of the cost of medicines used in the facilities, there was a clause to exempt the poor from payment. However, the criterion for identifying the poor was not clear and consequently, its implementation was left to the discretion of the health workers (Badasu, 2004). The National Health Insurance was subsequently introduced to "secure the provision of basic health care services to persons resident in the country" (Republic of Ghana, 2003). Even though the health insurance had mechanisms for exempting the poor from payment, the evidence shows that after a few years

of implementation of the scheme, in 2009, 27% of persons from the poorest quintile compared to 41% from the richest quintile were enrolled on the scheme (Jehu-Appiah, et al., 2011). This implies that out of pocket payments still remained an issue for the vast majority of Ghanaians, who were not covered by the National Health Insurance, when they had to contend with when seeking health care.

In describing the financial barriers and challenges to health care, the community members indicated the various scenarios and situations in which out-of-pocket payments had to be made. They highlighted how lack of money was a barrier in accessing health care as well as obtaining a suitable quality of care. When making the decision to seek care or not, the availability of money to the caregiver was critical, as expressed by a caregiver in one focus group discussion:

"*Because of the hardship, let's say the previous night when she was going to bed her child is running a temperature, but because there is no money to take the child to the hospital, what they do is my sister if you have para(paracetamol) give me some meanwhile the sickness is not one that Para (paracetamol) can cure. It is some sickness that has attacked the child and by the time she will get the money and take the child to the hospital, then it has become a problem for the mother and the people at the hospital but if she had the money, she would have taken her child immediately to the hospital for treatment" (FGD- MF- 01).*

This illustrates the challenges faced by the poor in seeking care. In the absence of money, they have to resort of other means, such as self-medication, to provide care for their children. These medications, depending on the condition of the child, could end up doing more harm than good. In addition, the lack of money meant they would have to wait until they had secured the funds before they sought care for their children. With the common conditions affecting children, such as malaria, diarrhoea or pneumonia, early care seeking is crucial for effective treatment and prevention of complication and death (Geldsetzer et al., 2014). Delaying care-seeking for sick children on account of limited funds is a problem and has serious implications for mortality in children. Other health care decisions that were influenced by the availability of

funds were the use of herbal treatments and the compliance with referral. The health care decision to use herbal treatment was expressed by a caregiver in a focus group discussion as follows: "*The child might be ill, but because there is no money they will not go to the hospital, but rather do herbal medicine at home" (FGD- MF- 01).* This scenario demonstrates how the lack of funds meant caregivers or community members had no option but to revert to the use of herbal treatments, which tend to be cheaper and have more flexible payment options than the formal health system. Also, the availability of money affected the decision by caregivers to comply with referrals for higher levels of care. In some instances, caregivers may have had some money to seek care initially. However, these funds were usually exhausted in the primary facility and by the time the patient was referred, there was very little money for compliance, as explained by a caregiver: "*if the place you are referred to is far then it is there that you will face hardship, because the little money you sent there is already finished" (FGD- MF- 01)*. In such instances, where the caregivers did not have the money, they simply returned home with the sick child. The existence of out of pocket payment, therefore, affected the utilisation of health services and compliance with the treatments provided. The non-availability of funds made caregivers delay care-seeking, look for other options of treatment, such as herbal medication or not complying after being referred. This finding is in line with the literature, where the introduction of user-fees was found to decrease the utilisation of health services (Lagarde & Palmer, 2008).

Beyond the decision-making in relation to seeking care, the existence of the out of pocket payments affected the care received in the health facilities. The community members, who had enrolled on the National Health Insurance Scheme and had the card, were perceived to have better access to care at the facility. Whilst this was generally the case, there were instances where they still needed to make some payments to cover services or medicines that were not covered by the health insurance scheme. The situation was generally more precarious for the community members who had no health insurance. The general feeling therefore about health care was always about the money. This sentiment was expressed by a caregiver in a focus group discussion as follows: "*For this place they say it's the health they use, but after everything you*

will see there is the money issue too, so sometimes I don't understand it" (FGD- MF- 01). From this perspective, health care was always associated with money and the need to pay for services. The community members were of the view that if you were in hospital and had no money, you could eventually end up dying. The availability of money to pay for services was therefore considered a critical factor affecting the communities' access to health care.

The existence of out-of-pocket payments meant illness and accessing health care was associated with "hardship" for community members. This was particularly so since the occurrence of an illness could not be predicted, nor could the amount the funds required to pay for the services received. This unpredictability of the funds required, meant that caregivers and community members had borrowed money, sold their assets or worked to pay off loans contracted when accessing health care. One participant in the focus group discussion described her experience as follows: *"I remember my own sad story. I remember I had a child who was eight years and at that time I use to sew and the child got sick for five days, we did everything to the extent that I had to sell my clothes and in the end too, the child did not survive*" (FGD- MF- 01). Accessing health care was therefore driving community members further into poverty by having to selling their assets and going into debt. Whilst these are known coping strategies that have been commonly utilised in dealing with health expenditure (Leive & Xu, 2008) in several countries, the fact they still occur has major implications in relation to addressing inequity and health care for the poor.

6.3.1.2 Socio-cultural factors

In addition to the financial barriers, other factors affecting the utilisation of services were the socio-cultural dynamics of the community. Community members, particularly the caregivers, held some common values and norms which influenced their expectations of each other when attending the health services. These shared norms meant they placed a lot of importance on dress for caregivers when attending health services for the period after giving birth. There was, therefore, a lot of peer pressure exerted on the caregivers to conform to the correct standard

of dress. Caregivers who could not do so did not attend the service. This was explained by a caregiver in a focus group discussion as follows: "*sometimes when somebody gives birth, because she has no white clothes to put on she won't go, because immediately people see her, they will be gossiping about her and she might even hear. So, this is also something that prevents some women from going to weighing (FGD-MF-02)*". This negative peer pressure particularly affected teenage and poor mothers who had no resources to buy the required clothes and tended to be very shy and vulnerable and therefore, unlikely to use the services. This community or societal imposed standard of dressing was also perceived to result in "*competition among the mothers*", as described by a community health nurse. When this competition existed, the poor lost interest in the programme and would not attend. Woolcock and Narayan (2000) describe the shared values and norms in a community and how these lead to the members of the community being an integrated group, acting collectively. From this perspective, the society is expected to conform to community expectations, regardless of whether these place them in a detrimental position. Applying this concept to the issue of dressing for health care, it seems the community expectation was to dress in a particular way. Caregivers, who were not able to dress accordingly, chose to absent themselves from the health services rather than be non-conformist in their dress. Understanding the community values and perceptions in terms of how these affect care is thus critical.

Another socio-cultural factor that affected the utilisation of services, particularly amongst the poor, was their belief systems. Whilst not mentioned by the community participants, the health care providers felt community and religious beliefs, fuelled by illiteracy, were also major deterrents to seeking care amongst the poor. This "Spiritism" as described by a national level policy maker, has led to people seeking alternate means of care and not using the orthodox health care system. He commented that the health services were "*being highly competed against by these prayer camps, these spiritualists, these faith healers, these pastors with their billboards…"* (ID-NA-05) and this was a barrier to accessing health care. This view point was shared by the regional and district level health staff. One regional officer described the situation as, "*our prayer camps too are taking them all away*" (ID-RG-01), thus indicating the

extent to which these spiritual places were considered an alternative to seeking health care at health facilities. This belief system is influenced by the African traditional religion practised in Ghana, which believes in multiple causation of disease (White, 2015). Some diseases are believed to have spiritual causes and thus spiritual solutions are sought for them. A district manager elaborated on the existence of this belief system in the community as follows: *"Let us say the child has a condition; you realise this is a malnourished child that has to be monitored, but the parents say that this is bewitchment. So, they send the baby to a prayer camp or they are not allowing you to see the child. Sometimes they hide them*" (IDI-DS-MF-01. This appears to suggest the perceived causation of malnutrition amongst some community members is non-medical and although none of them express this explicitly, it could have affected the way they addressed care seeking. The existence of this belief system in the community has serious implications for health seeking behaviour, particularly amongst the poor, as demonstrated in an example recounted of a malnourished child found by health care workers in a prayer camp to receive care. This child apparently was taken by these health workers to the facility, but died soon after. The spiritual causation attributed to some diseases, particularly those affecting the poor, thus impacting negatively on their use of health services. In sum, the study findings show that socio-cultural values, norms and beliefs affected access to health services, particularly for the poor. Addressing these socio-cultural factors requires community as well as individual engagement so as to understand their generally held perspectives and their belief systems and try to find a consensus with them on how they might modify their behaviour in support of health care utilisation.

6.3.2 Health Provision and Health System Factors affecting the Delivery and uptake of Health Services to the Poor

The second group of factors, following household and community factors, which influence the uptake of services are those relating to the health service provision itself. Wagstaff et al. (2004) describe the ways in which the poor are disadvantaged in accessing good quality health care services. These include the geographic accessibility of the services, the availability of resources

for service delivery, the organisational and technical quality, the relevance and timeliness of the service provided. A number of these factors were mentioned by the participants as affecting the uptake of interventions amongst the poor. Geographical accessibility of the services was a key challenge, as it affected the ability of caregivers to seek care for their sick children. Transportation costs were considered by some caregivers and community members as a deterrent to seeking care. Caregivers indicated that even in the situations where the child had a health insurance card, accessing care could be a challenge, if there was no money for transport. They also mentioned the difficulty of getting transport that would take them to the facilities. These difficulties were reiterated by the community health nurses, who identified challenges, in particular, the poor road network that had a negative impact on community members' utilisation of health services, especially during the rainy season.

The technical and organisational quality of the health services also affected the utilisation by caregivers. Some cited various experiences where they felt they felt their child had not been given the appropriate treatment and hence, this had led to their decision not to use the particular facility again. One caregiver in an FGD described the community perception of the technical quality of care as follows: "*With the children when we take them to the hospital, they don't look after them well, so most people don't take their children to the hospital" (FGD- MF-01)*. The client's perception of the quality of care is critical in utilisation of services (Wagstaff et al., 2004). In addition to the perceived technical quality, the attitude of the nurses and other health providers was also a deterrent for some caregivers. The participants mentioned that the nurses made negative remarks towards the caregivers. One caregiver in an FGD described her experience: "*at that time, my little child was sick and I took her there (the health facility). When I went, I was asked for my health insurance card, which I told her I didn't have, to which she made a statement like, 'if it had to do with buying meat, I will get money and buy. So, because of that statement I was shy and then just decided not to go again"(FGD-MF-02).* The lack of courtesy by the nurses was a major source of embarrassment and affected subsequent use of the facilities. Another caregiver in an in-depth interview expressed a similar feeling: "*When you go for weighing and you are late they won't serve you, they even insult you in front of*

*everybody when it happens that way then you become very shy" (*IDI-case narrative*).* These experiences provide evidence of the perceived negative attitudes of health professionals by the caregivers, which in some cases was putting them off utilising health care services. There is a lot of anecdotal evidence about the negative attitude of health workers in the health sector in Ghana and other countries (Bannerman et al., 2010; Mannava et al., 2015). The fact that the negative attitudes persist could be due to the limited understanding of the concept of quality of care, the inappropriate perception of professionalism as well as the lack of accountability on the part of the health providers. Two health care professionals in line with the perspective of the caregivers were also of the view that the health care system was generally very formal and thus, intimidating to the poor and uneducated caregivers. In sum, these perspectives demonstrate the extent to which poor courtesy shown to clients has a negative effect on their utilisation of health facilities.

In addition, the lack of appropriate resources and materials for service delivery impacted on the delivery and utilisation of services by the poor. As explained in the preceding chapters, this programme was funded with support by the World Bank to increase the utilisation child nutrition interventions at the community level. Whilst the programme in terms of its objectives did not specifically target the poor, by focusing on areas with high rates of malnutrition, it indirectly did so due to the links between poverty and malnutrition. At the time of the study, the project had come to an end and participants expressed concern about the sustainability of the programme. During the phase of project implementation, the volunteers were given some allowances which served as an incentive to provide services. Whilst some volunteers were still providing support, this was often irregular as they needed to find some other means of sustaining themselves in the midst of the dwindling resources. This meant they could not effectively support service delivery and mobilisation of caregivers to attend the sessions. The lack of resources to pay the allowances to the volunteers meant they did not have access to transportation so as to be able to submit their reports to the community health nurses. This example of the dwindling resources for the CGP programme demonstrates the effect on utilisation, particularly by the poor.

The limited resources also affected the materials and logistics required for the sessions. Caregivers indicated they needed to sew together or buy weighing pants to take along when they attended the weighing sessions. These were initially provided free of charge to the caregivers, however, with the dwindling resources they now needed to pay for them. Those who were unable to obtain them did not attend the sessions. The community health nurses reported that funds for transport to travel to support the growth promotion sessions were not always available and this affected their ability to be present and offer complementary services, such as immunisation. Also, some equipment, such as the scales, might be faulty and thus, the services could not be provided. The limited resources available for service delivery meant that the services could not be provided as intended and this affected their utilisation.

A further challenge expressed in addressing the health care needs of the poor, was the limited monitoring within the health system to track the health outcomes amongst the poor and the associated accountability. In relation to the monitoring of the health service outputs, the indicators were aggregated at district level with limited scrutiny of the performance of the different communities contributing the average figure. Also at community level, whilst achieving high coverages of interventions of around 80%, there was the tendency to overlook the remaining 20% who were most likely to be the poor and marginalised (Victora et al., 2003). The feeling at the national level was that health care providers at the community level should be able to account for 100% of the children under their jurisdiction, whereby none would be absented from the interventions. The Ministry of Health, Ghana, in its Annual Work Plan has included some indicators to monitor annual equity trends in mortality of children under-five years of age, human resource distribution and financial protection (Ministry of Health, 2015). These indicators are compared across regions, (least / most deprived) and across the wealth quintile groups, using population-based survey data. There may be the need to expand this framework to include more indicators on the coverage of interventions as well as intra-regional and urban/rural comparisons. Further application at the lower levels of administration at

Regional and District level together with the engagement of stakeholders should be considered so as to strengthen the accountability at all levels.

6.3.3 Health Policies and Actions Affecting the use of Services by the Poor

There were in place a number of government policies and actions with the potential to affect the delivery and uptake of services to the poor. However, there were challenges in operationalisation of these policies. The district level providers spoke about a directive that had been issued by the Director General of the Ghana Health Service to expand the Community Health Planning Services (CHPS) in their respective districts and communities. The directive had stated that a community health officer should be assigned to each electoral area within the region. However, there were not adequate numbers of community health officers in the districts to implement this directive. This could be linked to the general challenge of mobilising human and other resources to deprived areas, which was raised by a national level participant. That is, health workers were very reluctant to take postings to the deprived areas and this affected the availability of human resources to deliver care to the poor. Consequently, whilst the intention of the Government was a pro-poor approach, the limitation of resources was affecting its implementation in the poor and deprived areas.

Another example of the inadequate resources for implementing government policies was in relation to the provision of certain preventive child health services, such as growth monitoring and immunisation free of charge to the clients. A district manager expressed a sense of frustration owing to limited resources:

> *You see, the Ministry of Health brings us the policies and we implement them. …but let me just use this free, free kind of policy. The policy says the service is free and it is being carried out free. But we know the provision of the service goes with certain logistics; so that if these logistics are been made available day in and day out it makes the work a bit easier. ……..You see, much as you want to provide, there are obstacles; because you*

don't have free flow of even your logistics that you have to work with. So, it becomes a bit of a challenge." (IDI-DS-MF-01)

This lack of logistics is most likely to be due to inadequate funding allocated to the programmes to implement the policy of providing services free of charge to clients. Limited human and financial resources have previously been found to be barriers to effective policy implementation in Ghana (Awenva et al., 2010). Effectively addressing the implementation of the policies would require adequate allocation of resources. The Ghana Health Service uses a decentralised resource allocation process, whereby Regional Health Directorates are given a budget ceiling which they allocate to their respective Districts (Asante et al., 2006). Allocating adequate resources for programmes is, therefore, the responsibility of Regional and District levels. In the case of CGP, when the external source of funds from the World Bank was available, the programme was well resourced with all the requisite logistics. However, with the end of the project the resources dried up and this had an effect on the sustainability of the services. These examples show that the existence of government policies without the required resources to implement them, make their operationalisation ineffective.

Another demonstration of ineffective implementation of policy was the case of the National Health Insurance Scheme, which was put in place to increase access to health care and address inequity in health delivery (Republic of Ghana, 2003). The district level participants reported there was limited uptake of the scheme in the communities, because the registration process required travel by community members to the district capital. This meant that people living in deprived communities required money to travel to register and gain access to the scheme. At the community level, the situation was described as such by a community leader: "*there are a lot of people in this community who do not even have the health insurance card all because of poverty*" (IDI-CL-MF-02). Whilst the poor were supposed to be exempt from paying the premium for the scheme, they could end up not benefiting due to the difficulty in registering the services and/or inability to pay the premiums. The District Health Management Team tried to circumvent the hurdle of travelling to register by starting a system of registration in the community. However, this could not continue with the introduction of the biometric system of

registration. The institutional and organisational arrangements within the National Health Insurance Scheme also appear to have affected the uptake of the intervention amongst the poor. The low uptake of the NHIS, particularly amongst the poor, has been confirmed by various studies (Jehu-Appiah et al., 2011; Kotoh & Van der Geest, 2016), thus exposing the operational challenges in implementing the pro-poor policies such that they reach the poor.

6.3.4 Addressing the Health Care Needs of the Poor

In addressing the health care needs of the poor, one of the key considerations is identifying who they are and targeting them for interventions (Badasu, 2004; Hanson et al., 2008). The Ghana Health Service and the Ministry of Health in the national programming has been guided mainly by inter-regional variation in poverty and hence, in addressing inequity has focused on the four poorest regions identified by the Ghana Poverty Reduction Strategy. By using these criteria, there has been inadequate attention paid to intra-regional, intra-district and rural-urban variations in poverty at the national level, as the expectation is that the regions are best placed to address these (Asante et al., 2006). Despite the limited focus in the national documents on intra-regional poverty (Ministry of Health, 2015), the national level stakeholders, as has been discussed in the preceding chapters, have expressed some concerns on how to identify the poor. For the CGP programme, there was some targeting by the Regional and District Health Directorate, which focused the intervention on the deprived districts and communities using various criteria of depravity. To contribute to the understanding of poverty and the criteria for identifying the poor, community perspectives of poverty were thus explored.

There were various concepts of poverty brought to the fore by the community participants, which included the seasonal nature of poverty, whereby it was linked to the time of the year in the farming season when planting had been done and farmers were waiting for their harvest. This pressure was also found soon after Christmas when a lot of spending had taken place for the festivities. Poverty was considered at both the communal and individual levels. In the

fishing community, the participants were of the view the fishing was on the decline and this had affected the entire community. Being the mainstay occupation for the community, the decline in fishing had affected all the small scale income generating activities. There were also some criteria proposed for identifying poor individuals in the community. These included those who did not have enough to eat, or struggled with paying for services, such as school fees for their children, those who had many children (four or more) and those who were sick. These concepts of poverty, as suggested by the community, need to be considered for application within the health sector. It is crucial that district and community providers recognise the times of year when poverty is most prevalent and strategize to ensure the continuity of health care utilisation. Interventions, such as registration for health insurance, could be prioritised during the period of plenty when funds are readily available to support the payment of premiums and transport costs as required. The high prevalence of poverty at the communal level necessitates interventions for the poor being implemented using geographic targeting (Jehu-Appiah, et al., 2009). Participatory wealth ranking, which utilises community perceptions and inputs in identifying the poor at individual level, has achieved good results in rural settings (Jehu-Appiah et al., 2009). The method, however, does have its weaknesses in terms of the inclusion and exclusion errors. Also, since it involves applying a subjective measure of poverty, it may be inappropriate to apply across the country (Aryeetey et al., 2010). Nevertheless, at the community and district level, where health providers decide who should benefit from exemptions, this method could provide some guidance that would help in implementing national policies. The criteria proposed for identifying individuals would require some collaboration with other sectors, such as education and community development.

In addition to targeting the poor for services, addressing their health care needs requires strategies that address the barriers, including lack of financial access, limited health care provision and unhelpful sociocultural belief systems (Wagstaff et al., 2004). There were a number of ways proposed to address these issues, such as removing the fees for services, providing client friendly services, community empowerment, and integration of services

addressing the poor and increasing the availability of human resources in poor and deprived areas. These are discussed in detail in the ensuing paragraphs.

There was a call from the community to address the financial barriers, as expressed by one of the participants of a focus group discussion: "*What I want them to do is that they should talk to them so that they will stop finding ways and means to take money from us, because in the first place there are no jobs in the town" (FGD- MF- 01).* This indicates the weariness of community members with persistent collection of various fees by the health workers as well as their own personal challenges in meeting the required costs. Some of these fees that needed to be halted were the informal payments made for services, such as for the weighing pants for CGP, the Road to Health Card and medicine for minor ailments that was supposed to be provided free of charge. Addressing this would require the programme to be adequately resourced and providing medicines and other requirements free of charge at the point of service delivery. Research has shown that when resources are not available to implement the policies, frontline health workers make various financial modifications to cope with the situation and continue to provide services (Agyepong & Nagai, 2011), which impact negatively on the end users. Changing the practice of collecting any such fees would obviously require extra resources.

In addition to lowering the financial costs of care, there were a number of other ways suggested to improve health service provision and thus, increase the uptake by the poor. These included the provision of health services close to the clients, the provision of client friendly services as well as increasing material and human resources for service delivery to the poor. To minimise the geographic barriers and associated difficulties with transportation, it was proposed that the care should be brought closer to the client by expanding the scope of work of the community volunteers to include the management of sick children. Integrated community case management (iCCM) is a recognised equity-focused strategy aimed at increasing access to care for children less than five years of age (World Health Organization; UNICEF, 2012). In Ghana, the strategy has been implemented in a number of communities. However, there needs to be a scale up of this so as to reach many more children, particularly the poor in hard to reach

areas. Other suggestions for improving the health service provision were changing the attitudes of the health workers and making the services more client-friendly. The desired mind change for the health workers providing these services was expressed by a community leader as follows:

> *"….. for the nurses we know they have been to school and they have knowledge about some things and they are far ahead of some of the nursing mothers. So, they must be told to come down to the level of the community members, because someone may do something that will annoy you so they must be patient to everybody that comes to them for help. If they did not need your help they wouldn't have come to you, but because they needed you that is why they come to you. So, if they do something bad then you tell them in a humble way that this is not good and when you do it that way it will help a lot" (IDI-CL-MF-01).*

This proposed change in paradigm is in accordance with the Patient Charter of the Ghana Health Service, which states that health facilities (or health care workers) "…must be sensitive to patient's socio-cultural and religious backgrounds, age, gender and other differences……." (Ghana Health Service, 2015). The challenge, however, is in implementing a change of mind set.

Another aspect of improving the health service provision that was suggested by the participants was the need to increase and retain the human resources in poor and deprived areas. These participants proposed the establishment of Community Health Planning Services (CHPS) zones in more communities to deliver services to the poor. The Government adopted the Community Health Planning Services strategy in 1999 to increase the presence of community health officers in the community, thus bringing services close to the doorstep of the population (Policy Planning Monitoring and Evaluation Division, Ghana Health Service, 2002). The strategy has been fraught with several implementation challenges and as at 2012, it was found that only 5% of the population was covered by the CHPS services (Ministry of Health, 2016). The current CHPS Policy (Ministry of Health, 2016) outlines the Ministry's renewed effort to improve the implementation of the CHPS strategy so as to increase the coverage and thus, achieve better outcomes with the strategy. Linked to the CHPS strategy is the deployment of community

volunteers. They were recruited by the Ministry of Health for a period, with the adoption of the CHPS strategy in 1999 and this became the platform through which the community volunteers were to be mobilised. Specifically, part of the CHPS Policy was to address the issue of training, retaining and incentivising volunteers, thus leading to better access to health care for the poor.

In addition to lowering financial costs, and improving health service provision, the third area suggested for improvement was community education and empowerment. Regarding the key challenges in accessing health care due to sociocultural beliefs and practices, it was proposed the community should be educated and empowered to take better decisions in relation to their health. Research has shown that behaviour change strategies and informal education of caregivers can lead to the adoption of positive health practices (Wagstaff et al., 2004). The provision of some incentives, such as food to poor caregivers, donations of babies' clothes to pregnant women and giving birth at the facilities, was put forward to encourage them to attend the growth monitoring sessions. The use of incentives in the form of conditional cash transfers has been applied in a number of countries (Fiszbein et al., 2009), with successful outcomes in terms of increasing the utilisation of health services. However, the application of such an incentive scheme would require adequate resources and some form of targeting of the poor so that they can benefit from such schemes.

6.4 Conclusion

This chapter set out to identify the factors that affect the use of health services by the poor. Applying the policy triangle (Walt & Gilson, 1994) as the overarching framework guiding the analysis, the broader contextual issues of reaching the poor with a health service have been addressed. The analysis involved also drawing upon the framework on the determinants of health outcomes (Wagstaff, 2002), focusing on household and community factors, health service provision, health system and policy as well as proposed actions to improve uptake among the poor. Whilst the broad findings are not different from those in the existing literature, the specific contextual issues provide some new insight into the key concerns that

affect the delivery and uptake of services amongst the poor at community level as well as the proposed solutions.

One of the main deterrents to seeking health care at the community and household level was the financial costs associated with the provision of almost all health services. Despite the government policies on exemptions and the institution of the National Health Insurance Scheme, out-of-pocket payments for health services were still a reality for many community members. These payments were required, because some did not have health insurance, there were additional payment required for items not covered by the insurance or there informal payments for the various services received. The rationale for these payments was poorly understood by the community members in some instances. The need for out-of-pocket payments at the point of service provision delayed care-seeking, affected compliance with referrals and led people who did not have money readily available to seek alternate means of care. Where care was sought at the facilities, conditions were better for those with health insurance as they generally had to pay less than those without it. As neither the onset of illness nor the cost of care could be determined in advance, they could not plan adequately for these contingencies and so health care costs drove families into debt, with loss of their assets in many cases.

Sociocultural and community values, norms and beliefs continue to negatively affect care seeking behaviours and practices, particularly amongst the poor. The community norm of dressing appropriately for a visit to the health facilities for growth monitoring and promotion services was a major deterrent amongst the poor to accessing health care. In addition, the belief systems about the causation of disease, fuelled by poverty and illiteracy, led caregivers to seek care at traditional healers or prayer camps. This was particularly worrying as care was sought for conditions that mainly affect the poor, such as malnutrition, for which known interventions exist to address them. Understanding the socio-cultural values, norms and beliefs is thus critical when trying to remove health care barriers.

Another deterrent to care seeking was the nature of health service provision. Geographic accessibility and the associated transportation difficulties prevented the poor from readily seeking care at health facilities. In addition, poor attitude of the health providers and inappropriate care being given previously were factors that made people reluctant to continue obtaining health care. Other broader health system issues also influenced indirectly the delivery and uptake of care by the poor. The inadequate resources for service provision affected the quality of care provided in the community interventions. Also, the limited focus on equity monitoring, reduced the level of accountability and consequently, the actions aimed at ensuring equity in service delivery.

The ineffective implementation of the National policies also negatively impacted on the delivery of health services to the poor and their uptake by them. There were a number of exemption policies and a health insurance scheme that were supposed to eliminate the payment for clients at the point of care. However a lack of adequate resources and the inappropriate strategies for operationalisation, led to ineffective policy implementation. Whilst various services were to be provided free of charge and/or were to target the poor, the reality was different on account of the limited funding for the programme.

There were a number of suggestions made by the participants – stakeholders at all levels. However, fulfilling the best of these would require increased attention to planning as well as improved budgeting and increased resource allocation. Increasing the uptake of health services amongst the poor would require actions at the household and community levels as well at the policy and different health provision levels. Some of the actions that need to be taken are addressing the financial barriers to health care by removal of fees for services, providing client friendly services, empowering the community and increasing the availability of human and material resources in poor and deprived areas. In sum, meeting the health care needs of the poor such that they are willing engage with services is what is needed if universal coverage is to be achieved.

Chapter 7: Conclusion

7.1 Introduction

This concluding chapter of the thesis summarises and reflects upon the key findings from the research, bringing together the three key components of the study in the empirical chapters. In doing so, the chapter synthesises the findings and conclusions around the philosophy of equity amongst the health care providers; the consideration of equity in agenda setting and implementation of community growth promotion and the factors affecting the uptake of health interventions amongst the poor. The chapter begins with a review of the study the main objectives, and how these have been addressed by the findings. This is followed by a synthesis of the findings and conclusions and recommendations for policy and practice. The chapter comes to a close with some concluding thoughts on the methodology and its applicability in other contexts, followed by a brief discussion of areas for further research.

7.2 Review of Study Objectives

The aim of the study was to explore and understand how a preventive health care service – Community Growth Promotion – was structured and delivered to reach the poor. As a priority programme implemented by the Ministry of Health, the research sought to ascertain how well aligned this programme is with the pro-poor policy thrust of the Ministry of Health. The objectives of the study were therefore as follows:

- To understand the experience of implementing community growth promotion from the perspectives of the implementing actors at the regional, district and community levels, with specific focus on its delivery to the poor and marginalised.

- To conduct an analysis of equity issues in the Community Growth Promotion (CGP) programme in Ghana.
- To understand the factors that influences the uptake of interventions among the poor at the community level.

These objectives were addressed by carrying out a case study of the CGP, utilising the policy analysis approach. The first objective was achieved by carrying out in-depth interviews with stakeholders involved in planning and implementing CGP to understand their perspectives on health equities and how this was integrated in their work. These stakeholders included the policy formulation actors - governmental officials (civil servants) from the national level of the Ministry of Health and the Ghana Health Service, implementation actors at regional, district, sub-district and community level of the health sector. The data generated from these in-depth interviews provided their perspectives on health equity. These in-depth interviews, complemented by additional in-depth interviews and focus group discussions with community members, as well as documentary analysis were utilised to generate information to understand the content, context and process of CGP and the extent to which issues of equity were integrated, thus also addressing the second objective. Finally, putting together the information generated from the in-depth interviews and the focus group discussions enabled the understanding of factors influencing the uptake of interventions amongst the poor at community level, thus achieving the third objective. The health policy analysis was a useful approach which enabled me to achieve the aim of the study.

7.3 Summary and discussion of findings:

The literature, upon which this study was premised, indicated the richness in the evidence on the prevalence on health inequities and their determinants, but rather limited evidence on the proposed solutions in addressing the inequities. As countries move into the era of the Sustainable Development Goals (SDG), one of the critical targets they will need to achieve is reducing inequities, and hence the need for more attention to implementation research in this area (Rasanathan & Diaz, 2016). The results from this study raises the importance of

understanding the processes and perspectives of stakeholders for successful implementation of policies and programmes aimed at addressing health inequities The findings are therefore critical as they contribute to the body of knowledge on the implementing policies and programmes to address the delivery of health care to the poor. Specifically, these findings have brought to the fore, the perspectives of a range of stakeholders, and the extent to which consider equity in setting the agenda, formulating and implementing health policy and programmes; the implementation challenges in programmes, as well as the persistent barriers to health care for the poor. The findings of the study were analysed and presented according to the themes of the objectives. In the following section, I summarise the key findings from each thematic area and triangulate across the thematic areas in order to provide a deeper understanding.

7.3.1 Philosophy of equity amongst health workers at all tiers of health system.

The first objective focused on the philosophy of health equity amongst the policy-making and implementation actors. The study brought to the fore the range of actors involved in policy and programme process and the importance of identifying them, understanding their perspectives and how this impacts on their role. The findings showed that majority of these actors recognised the need for attention to health care for the poor on account of the challenges they face in accessing care. At national level, the stakeholders seemed to be driven by the pro-poor priority of the government, whereas at the district and community levels, they were influenced more by their observations of the difficulty clients have in accessing services on account of poverty. This perception influenced their response in meeting the health care needs of the poor, by addressing the geographic and financial barriers to care. The stakeholders at the national, regional and district levels knew of the national pro-poor strategies and believed they were of relevance; however there was a feeling among some, that they were powerless to implement these strategies with limited resources. The findings from this study have provided some insight into the formulation and implementation actors' perspectives of poverty, health and inequity, as well as their perceived roles and abilities in affecting the policy process. The

majority of these actors recognised the existence of health inequities and the need to address them. However, there were different drivers for this recognition at national and sub-national levels respectively, and this influenced their response to addressing health inequities.This highlights the importance on knowing, understanding and influencing the philosophy of stakeholders in addressing health inequities.

7.3.2 Analysis of equity issues in the Community Growth Promotion (CGP) programme in Ghana

The second objective addressed the extent to which the CGP programme was structured to reach the poor and the extent to which the actors factored equity considerations into their implementation of it. The study found that, although issues of poverty and health inequities were not in the fore in agenda setting and formulation stages, they were indirectly addressed through the content, structure, and context of the CGP. The main driver found to have influenced the agenda-setting of the CGP programme was the high prevalence of malnutrition in the country. However, due to the strong association between poverty and malnutrition, issues of poverty were indirectly considered. The structure of CGP – a community–based intervention – addressed the health care needs of the poor, as it provided services closer to the clients, thereby eliminating transportation costs and increasing geographic access, which is usually a challenge for the poor. Due the association of malnutrition with poverty, the implementing regions with the highest prevalence of malnutrition were also the regions with higher rates of poverty, thereby addressing health inequities. Thus, health equity considerations were indirectly addressed in the planning and formulation of CGP through the linkages with the factors associated with poverty. These findings bring to the fore the significance of the multi-dimensional nature as well as the factors associated with poverty, and how the considerations of these dimensions, such as malnutrition contribute to address health inequities.

Another key finding from the study was the observed variation in addressing equity at the level of implementation. Even though the CGP was structured to increase access and focus on

diseases and conditions associated with poverty, regarding its actual implementation, there were some barriers to achieving the outcomes. The study thus demonstrated the variance between the proposed objectives, the actual implementation as well as the experience of the end-users. It highlights the importance of allocating adequate resources, and monitoring the implementation to ensure the delivery is in accordance with the set objectives, meets the needs and expectations of the end-users, and is acceptable and accessible to them. Thus, putting in place programmes to address equity is not adequate; they must be well operationalised to ensure the expected outcomes are achieved.

Further in relation to the structure and delivery of CGP, the study found differing degrees to which the health workers and volunteers integrated equity issues in planning and implementing it. Issues of poverty and health inequity were not the foremost consideration for the national level stakeholders when setting the agenda, planning and formulating CGP. This is in contrast to the district and community level health providers, particularly the community health nurses, who placed much more emphasis on poverty and equity issues in their work. Triangulating the findings from the first two objectives gives a rather interesting picture. Whereas the national stakeholders were very conscious of the pro-poor agenda, this was not given foremost consideration in their planning of CGP. The over-riding consideration at the national level was the agenda to address malnutrition and the window of opportunity created by World Bank funds. In discussing equity, the national actors felt the actions needed to be taken more at regional and district level, particularly in the allocation of resources and the selection of the focus districts for implementation. In contrast, stakeholders at the district and community levels factored in equity issues in the selection of the CGP implementation areas and the provision of outreach services. The study has, therefore, shown that considerations of poverty and equity issues differ amongst the actors depending on their perceived role and ability in addressing health inequities. This implies that programmes and policies should be more in intentional incorporating equity considerations, and not leave these solely to the discretion of the actors.

7.3.3. The factors that influence the uptake of interventions among the poor at the community level.

The final objective was focused on the factors that affect the use of health services by the poor. The study highlighted key factors at household and community, health service provision, health system and policy levels that influenced the uptake of services by the poor. Whilst the broad findings are not different from those in the existing literature, the specific contextual issues provided some insight into the key concerns that affect the poor in accessing services. Key amongst these was the various user-fees or out of pocket payments (OOP) that created financial barriers to accessing health care by the poor. Other factors were sociocultural and community values, norms and beliefs, and the nature of health service provision. The study also brought to the fore how the ineffective implementation of national policies aimed at addressing inequities negatively impacted on the delivery and uptake of health services by the poor. Thus, reaching the poor with health services therefore requires active engagement with the community to know and understand their values and belief systems, as well as their perception of health provision and barriers to accessing care; and ensuring effective implementation of the policies and programmes to address these barriers.

Based on these factors identified, and supported by other findings, a number of actions were proposed to address the health inequities. These are outlined in the ensuing section.

7.4 Recommendations for Policy and practice

The key findings of the thesis have highlighted various strengths to be enforced, and weaknesses to be addressed. Based on these, a number of recommended actions are proposed for policy and practice. These are outlined below:

- One key recommendation emerging from the perceptions of the key stakeholders was the need for more effective communication on national priorities, particularly in addressing health equity. This is critical to ensure that all the providers at the various tiers of the health system are apprised of the common goal and work towards it (McIntyre & Klugman, 2003). Such communication should take into account the perspectives of these providers and the underlying drivers to address the direct concerns and issues that enhance their perspectives.
- Another key recommendation arising from the experience of implementing CGP is the need to engage in regular monitoring of interventions which address health inequities, to ensure the delivery is in accordance with the set objectives. This is critical to ensure that there are no conditions that serve as barriers, thereby limiting access to the services. The use of monitoring in collaboration with the community and other stakeholders in an essential component of this recommendation.
- The third key recommendation, arising from the understanding of the factors influencing the uptake of interventions, is the need to address the major barriers to health. Some recommended actions are to address the financial barriers to health care, provide client friendly services and empower the community to be more knowledgeable and improve health literacy.
- Finally, the fourth recommendation, also arising from the understanding of the factors influencing the uptake of interventions, is the need for adequate allocation of resources to facilitate more effective implementation of health policies and strategies addressing the needs of the poor. This is important to ensure that in the face of limited resources, frontline health workers do not introduce various payments to cope with the situation and continue to provide services (Agyepong & Nagai, 2011), thereby affecting utilisation by the poor.

7.5. Implications for future research

Although this study has provided evidence on the perspectives of stakeholders, the equity considerations in the CGP and the factors affecting uptake of health services by the poor, there are still important additional questions to be addressed that are beyond the scope of the study. In exploring the perspectives of stakeholders, the focus of this thesis was limited mainly to governmental and community actors. Future studies should consider other actors such as developmental agencies and professional bodies to understand their perspectives and influence on equity issues. Secondly, in exploring perspectives, the study revealed that the concept of "social distance" (Bloch et al., 2011) was important to explain the non-recognition of health inequities and the need to address them. Although this concept was proffered, it is not clear how applicable it is in the context of the community, and in low-income countries. Future studies need to explore this concept further, particularly in different settings. The study also brought to the fore the challenges in maintaining adequate resources for strategies to address equity. Future research should explore health financing options that provide sustainable financing for programmes to address the health care needs of the poor.

7.6 Methodological issues and limitations

This case study of CGP was carried out applying the health policy analysis approach proposed by Gilson et al. (2006) in addressing the issues and challenges encountered in the implementation of programmes directed towards the poor and marginalised. The strength of the approach is the ability to understand the stakeholders and factors affecting implementation. Drawing upon a number of frameworks and theories of policy analysis (Walt et al, 2008), this study has produced a novel approach for reviewing a programme to assess the extent to which equity considerations are factored in the various stages of planning and implementation, addressing content, context, process and actors as proposed in the policy framework by Walt and Gilson (1994). As countries strive to address health inequities, the monitoring of programmes will be critical to ensure they are in accordance with the national

priorities. This methodology will be useful in such contexts. However, despite its strengths, there are limitations in the approach utilised. As a qualitative study, this was conducted in a specific setting and hence the findings cannot necessarily be generalised. In addition, the stakeholders included in the study did not include the entire range of those involved in the CGP. However, in sum, the methodology used has provided a comprehensive approach to explore issues of equity in programme planning and implementation.

7.7 Concluding remarks

This equity analysis of the CGP undertaken in this thesis has provided the opportunity to gain insight into the perspectives of the stakeholders at all levels of the health system and within the community, on issues that concern poverty, health and equity, and more specifically, how these influence programming. The study has enabled me to critically examine the CGP and whether it addresses the needs of the poor. Many of the findings can be corroborated in other studies undertaken in different contexts. But perhaps most importantly, the evidence in this study can clearly be used to inform an agenda for action. Examples of such action include the orientation of health providers on health inequities and the need to address them, the adequate allocation of resources for services for the poor and the engagement of community stakeholders in ensuring acceptability and use of services for the poor. To close on a more personal note, the experience of undertaking this qualitative study has also been a long journey and a steep learning curve. Through this journey, I have been afforded the rare opportunity to enter the minds of a wide range of people, to gain insight on their views, understand their situations, and make sense of the challenges that confront them.

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A. Appendices

Appendix 1: Study Materials

Letter seeking permission for study

[redacted]

01 November 2013

The Director General
Ghana Health Service
Accra

Dear Sir,

REQUEST FOR PERMISSION TO CARRY OUT A QUALITATIVE CASE STUDY OF COMMUNITY GROWTH PROMOTION TOWARDS THE AWARD OF A PROFESSIONAL DOCTORATE HEALTH

I write to request for permission to carry out the above-mentioned study which is towards the award of a Professional Doctorate of Health, with the University of Bath, United Kingdom.

The study aims to explore the extent to which preventive health care services are structured to reach the poor. This will be done using the community growth promotion as a case study. The objective will therefore be to explore how equity issues are considered as health interventions are scaled down through the various tiers of the health system. It will also explore factors affecting the delivery and uptake of the intervention.

Multiple data collection methods including documentary analysis, in-depth interviews and focus group discussions will be employed during the study. Data collection will be done at the national level, Central Regional Health Directorate, and two districts in the Central Region respectively. It is expected that the results from the study will contribute towards the body of knowledge on health programming to reach the poor.

I would be funding this study from my personal resources.

I would be grateful if this request is given attention.

Yours sincerely,

[redacted]

MARY NANA AMA BRANTUO
Student – Professional Doctorate in Health, University of Bath, United Kingdom
National Professional Officer – Child and Adolescent Health, WHO/Ghana

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[redacted]

[redacted]

[redacted] regards,

[redacted]

Mary N. A. Brantuo

[redacted]

Information Sheets and Consent Forms for Respondents in English and local language

Information Sheets and Consent Forms for Health Workers

Information Sheets and Consent Forms for Respondents

Name of Organization: University of Bath

Research: How are preventive child health services structured to reach the poor: A qualitative case study of Community Growth Promotion in Ghana.

Information Sheet for the Health Workers

My name is ……. I am research assistant working with Dr Mary Nana Ama Brantuo of the World Health Organization. She is studying for a professional doctorate in Health and as part of her study; she is conducting research about child health services in the community.

Purpose of the research:

The study aims to explore how the community growth promotion programme is structured and delivered to reach the poor. This research will therefore look at the organisation of the community growth promotion programme, and how the services are provided. Lessons from this study will help in planning other programmes more effectively to reach the poor.

Procedures

In this study, the community growth promotion programme documents will be looked at, and health workers at the national, regional, district sub-district and community levels will be interviewed to find out about the programme. In addition, there will be group discussions with caregivers who use the services at community level, and interviews with the community leaders.

Risks and Discomforts:

There is a minimal risk associated with your participation as a health worker in this study. If you agree to take part in this study, I will interview you at a time convenient to you. The interview will take between 45 to 60 minutes of your time. In addition, people may identify you as having contributed to the study due to fact that the research is known to be taking place in your region or district.

Benefits:

There will be no direct benefit to you; however your participation is likely to provide information that can help in understanding how programmes should be organised so that they meet the needs of the poor people.

Incentives:

You will not be provided any incentive to take part in this study.

Confidentiality:

Although people may identify you as having contributed to the study due to fact that the research is known to be taking place in your region or district, we will ensure that your responses are not linked to you. Information about you that will be collected from the study will be stored in a file which will not have your name on it. This information will be kept under lock and key, and will not be divulged to anyone except the members of the research team. When we present the findings of the research, your name will not be used in any publications.

Right to refuse or withdraw:

You do not have to take part in this study if you do not wish to do so. If you agree to take part, you can stop the interview at any time that you wish to. If you decide not to take part in this study, it will not affect your work and benefits that you would otherwise have as a health worker.

Who to contact:

If you have any questions you may ask those now or later. If you wish to ask questions later, please contact:

Dr Moses Aikins – School of Public Health, University of Ghana. Email: [redacted]

Ms Nita Coffie - Ag. Administrative Secretary, Ghana Health Service Ethical Review Committee, Research and Development Division, Ghana Health Service. Email: [redacted] Telephone: [redacted]

Dr Fiona Fox –University of Bath, United Kingdom, email: f.fox@bath.ac.uk, Telephone: +441225383621

Dr Mary Nana Ama Brantuo – World Health Organization, Namibia. [redacted]
Telephone - +[redacted]

Thank you for your time.

Name of Organization: University of Bath

Research: How are preventive child health services structured to reach the poor: A qualitative case study of Community Growth Promotion in Ghana.

Informed Consent Form for the Health Workers

O I have read the participant information sheet or it has been read to me and explained in my own language

O I have had the opportunity to ask questions about the study and any questions I have asked have been answered to my satisfaction

O I understand that I may withdraw from the study without penalty at any time by advising the researchers of this decision and that withdrawing will not affecting any way my work or the benefits I receive as a health worker.

O I understand that this project has been reviewed by, and received ethics clearance through, the Research Ethics Approval Committee for Health of the University of Bath

O I understand that only the research team will have access to personal data provided, and that the data will be stored securely.

O I agree to participate in the study

Name of Participant ……..

Signature…….. OR Thumbprint ……

Date ……..

Counter-signed

Name of Interviewer

Signature……..

Date ……..

Information Sheet for the Community Volunteers and Community Leaders

My name is …….. I am research assistant working with Dr Mary Nana Ama Brantuo of the World Health Organization. She is studying for a professional doctorate in Health and as part of her study; she is conducting research about child health services in the community.

Purpose of the research:

The study is looking at how the community growth promotion programme is planned and how the services are provided so that it reaches all the children who need it, especially those who do not have too much money. Lessons from this study will help in planning other programmes for children at the community level.

Procedures

In this study, the community growth promotion programme documents will be looked at, and health workers at the national, regional, district sub-district and community levels will be interviewed to find out about the programme. In addition, there will be group discussions with caregivers who use the services at community level, and interviews with the community leaders.

Risks and Discomforts:

You are not going to have too much problems if you take part in this study, apart from the use of your time. If you agree to take part in this study, I will interview you at a time convenient to you. The interview will take between 45 to 60 minutes of your time. In addition, people may identify you as having contributed to the study due to fact that the research is known to be taking place in your region or district.

Benefits:

There will be no direct benefit to you; however your participation is likely to provide information that can help in understanding how programmes should be planned so that they meet the needs of all the children who need it.

Incentives:

You will not be provided any incentive to take part in this study.

Confidentiality:

Although people may identify you as having contributed to the study due to fact that the research is known to be taking place in your region or district, we will ensure that your responses are not linked to you. Information about you that will be collected from the study will be stored in a file which will not have your name on it. This information will be kept under lock and key, and will not be shared with anyone except the members of the research team or myself. When we present the findings of the research, your name will not be used in any publications.

Right to refuse or withdraw:

You do not have to take part in this study if you do not wish to do so. If you agree to take part, you can stop the interview at any time that you wish to. If you decide not to take part in this study, it will not affect your work and benefits that you would otherwise have as a community volunteer or leader.

Who to contact:

If you have any questions you may ask those now or later. If you wish to ask questions later, you may contact:

Dr Moses Aikins – School of Public Health, University o[redacted]
Tel: +233244433743. P.O.Box LG 13, Legon, Accra.

Ms Nita Coffie - Ag. Administrative Secretary, Ghana Health Service Ethical Review Committee, Research and Development Division, Ghana Health Service. Email: n[redacted]
Telephone: [redacted]

Dr Fiona Fox –University of Bath, United Kingdom, email: f.fox@bath.ac.uk, Telephone: +441225383621

Dr Mary Nana Ama Brantuo – World Health Organization, Namibia. Email: b[redacted]

Thank you for your time.

Informed Consent Form for the Community Volunteers and Community Leaders

- ☐ I have read the participant information sheet or it has been read to me and explained in my own language
- ☐ I have had the opportunity to ask questions about the study and any questions I have asked have been answered to my satisfaction
- ☐ I understand that I may withdraw from the study at any time by advising the researchers of this decision and that withdrawing will not affect in any way the care that I or any member of my family would receive in any hospital or clinic or child health services or my benefits a community volunteer or leader.
- ☐ I understand that this project has been reviewed by, and received ethics clearance through, the Research Ethics Approval Committee for Health of the University of Bath, and the Ghana Health Service Ethics Review Committee.
- ☐ I understand that only the research team will have access to personal data provided, and that the data will be stored securely.
- ☐ I agree to participate in the study

Name of Participant ……..

Signature…… OR Thumbprint ……

Date …….

Counter-signed

Name of Interviewer.....

Signature……..

Date ……

Information Sheet and consent forms for the Caregivers

Name of Organization: University of Bath

Research: How are preventive child health services structured to reach the poor: A qualitative case study of Community Growth Promotion in Ghana.

Information Sheet for the Caregivers

My name is ……. I am research assistant working with Dr Mary Nana Ama Brantuo of the World Health Organization. She is studying for a professional doctorate in Health and as part of her study; she is conducting research about child health services in the community.

Purpose of the research:

The study is looking at how the community growth promotion programme is planned and how the services are provided so that it reaches all the children who need it, especially those who do not have too much money. Information from this study will help in planning other programmes for children at the community level.

Procedures

In this study, the community growth promotion programme documents will be looked at, and health workers at the national, regional, district sub-district and community levels will be interviewed to find out about the programme. In addition, there will be group discussions with caregivers who use the services at community level, and interviews with the community leaders.

Risks and Discomforts:

Taking part should not cause any problems for you apart from the use of your time. If you agree to take part in this study, you will join other members of the community in a discussion that will take about one hour to one and a half hours of your time.

Benefits:

There will be no direct gain to you, however if you participate, you may help the researcher to understand how programmes should be planned so that they meet the needs of all the children who need it.

Incentives:

You will not be provided any incentive to take part in this study. After the discussion, you will be provided with some light refreshment.

Confidentiality:

Information about you that will be collected from the study will be stored in a file which will not have your name on it. This information will be kept under lock and key, and will not be shared with anyone except the members of the research team or me.

Right to refuse or withdraw:

You do not have to take part in this study if you do not wish to do so. If you agree to take part, you can stop the discussion and leave at any time that you wish to. If you decide not to take part in this study, it will not affect the care you will receive for yourself or any of your children in any hospital or clinic or child health services.

Who to contact:

If you have any questions you may ask these now or later. If you wish to ask questions later, you may contact:

Dr Moses Aikins – School of Public Health, University of Ghana. Email: [redacted]

Ms Nita Coffie - Ag. Administrative Secretary, Ghana Health Service Ethical Review Committee, Research and Development Division, Ghana Health Service. Email: [redacted]

Dr Fiona Fox –University of Bath, United Kingdom, email: f.fox@bath.ac.uk, Telephone: +441225383621

Dr Mary Nana Ama Brantuo – World Health Organization, Namibia. Email: b[redacted],

Thank you for your time.

Informed Consent Form for the Caregivers

- ☐ I have read the participant information sheet or it has been read to me and explained in my own language
- ☐ I have had the opportunity to ask questions about the study and any questions I have asked have been answered to my satisfaction
- ☐ I understand that I may withdraw from the study at any time by advising the researchers of this decision and that withdrawing will not affect in any way the care that I or any member of my family would receive in any hospital or clinic or child health services.
- ☐ I understand that this project has been reviewed by, and received ethics clearance through, the Research Ethics Approval Committee for Health of the University of Bath, and the Ghana Health Service Ethics Review Committee.
- ☐ I understand that only the research team will have access to personal data provided, and that the data will be stored securely.
- ☐ I agree to participate in the study

Name of Participant ……..

Signature…… OR Thumbprint ……

Date …….

Counter-signed

Name of Interviewer

Signature……..

Date …….

Information Sheet and Consent form in Local Language
Ekuw Din: Suapɔn Bath

Nhwehwemu : ɛsi dɛn nɛ apɔmuden dwumadi etumi du mmɔborɔwafo wɔnnkyɛn? Nhwehwɛ mu aefaɔkwan a mpɔtam – mpɔtam apɔwmuden betumpɔn wɔ Ghana.

Krataa a ɛfaonipa a ɔyɛnhwehwɛ mu yi ho

Wɔfrɛ me ……. Meyɛboafo ma ɔbenfo Mary Nana AmaBrantuo a wodi ne dwuma wɔwiaseapɔwmudenkuwbaatanasoɛe wɔ Ghana.

ɔbenfo Nana AmaBrantuonamsaaadesuayi so benya ne dwumadi mu abɔdinsɛɔbenfo wɔapɔmuden mu na ne nhwehwɛmu no fammofraapɔwmudenne wɔn ayarehwɛwɔmpɔtam – mpɔtam.

Nhwehwɛ mu yibotae.

Nhwehwɛ mu yibɛhwɛɔkwan a yɛbɛfa so amampctam – mpɔtamapɔmudendwumadi no akɔ so ma abofrabiara a wohia no nsaatumi aka bi a ɛmfa ho ne beae a ɔwɔ hɔ.

Ne titioriwahiafo ne mmɔborɔwafo a wonnisika.Suahu a, ebefiadesuayimu aba no bɛboa ma y'ahwehwɛdwumadiahorowpii de aboammofra a wɔwɔnkuraase ne mpɔtamaohiaadokorowɔn.

Akwankyeɛ

Dwumadiyi mu no yɛbɛhwɛnkrataa a ɛkyerɛmpɔtam no mpɔmudenyiediampɔmudennnwumayɛfo a wɔwɔɔman yimpɔmudebasoeɛe, mantam, mansin ne mpɔtam no nyinara de wɔnnhwehwɛ mu bɛtogua. Bio nso, yɛnewɔn a wodiiwɔndwuma wɔmpɔtam – mpɔtam no ne wɔn a wodibano wɔmpɔtamhɔnobetwetwenkɔmmɔafadwumadi no ho.

ɔhaw ne Kɔdaɛnna

Nipa a wɔdewɔn ho bɛhyɛdwummadiyi mu no nnyaanidasomsɛwɔnbere a wɔdebɛma no pɛnaehiayɛn. saafo no bɛkawɔnnuanom a wagyeato mu dedaw no ho wɔakuoahorow mu de agyewɔnadwenkyerɛ. Dwumadiyibedidɔnhwerebiakoanaabiako ne fampo.

Mfaso:

ɛwɔmusɛhonamfa mu mfasobiaramfidwumadiyi mu mma de, nansow'ahofamabɛboa ma dwumadiyi de akwankyerɛ ne nhyehyɛe a ebetumiamammofraapɔmudenatumpɔn wɔ mpɔtam-mpɔtamayarehwɛ mu.

Mpata

Hu sɛmpatasikanni hɔ ma obiara a wɔde ne ho bɛhyɛsaadwumadiyi mu, nansosɛdwumadi no nyinaakɔ wie a wodeanoneɛ bi bɛmasaaatuhoakyefoyi de adwodwowɔn ho.

Banbɔ

Yɛbɔwoanohomasɛ, nsɛmbiara a gyɛbɛgyewɔwohc no, yɛbɛbɔɛbɛbya erenkɔnipafoforobiara hɔ, afeinsowɔde ne nyinaabeguadekorade mu ato mu safoa a onipa a dwumadiyisi ne nansonkotoonawokutasafoa no.

Ngyetom ne ntwesan

Obiara wɔ ho kwansɛɔbɛkadwumadiyi ho nasaaaransonaobiara wɔ hokwansɛwɔtwe ne ho fi dwumadi no mu,kaesɛdwumadi no nnyɛɔhyɛntisɛwotwewo ho a nsusuansobɔnebiarammawoanaawo ho nipabiaraapɔwmudenhwɛahorownyinaa mu.

Nkitahodiakwankyerɛ

Oiara wɔ ho kwansɛɔkyerɛn'adwenanaawobisansɛmbiara a ɛdan'akoma so, mpompremprenyiara. Na sɛwopɛsɛwoka no baanunkɔmɔnso a faakwankyereyi so;

Medaobiaraase

Apɔmudenadwumayɛfongye to mu krataa.

☐ Mankasamakenkannhyehyɛenwoma a woderedidwuma no anaa obi akenkanakyeɛ me ase wɔme kasaa mu ma mate aseɛ.

☐ menyaakwanbisaansɛmfaaadesuayi ho ne neaɛdam'akoma so nyinaa ho, ma onyaaberekyerɛɛ me mu yie.

☐ Woama mate asesɛ me tumiatwe me ho wɔdwumadiyi mu a, enyansusuansobɔnebiarawo me anaa me ho nipabiaraapɔmudenhwɛ mu

☐ Bagua a wɔhwɛsuapɔn Bath (university of Bath)adesuanhwehwɛ mu so amadwumadieyi ho kwan ma bagua Ghana apɔmudenasoeɛeapawwɔn no nsoagyeato mu

☐ Woama mate asesɛwɔn a wɔɔyɛnhwehwɛ mu no nkotoonawobenyannsɛmisanwomanohoakwanyaahwɛ mu asanabɔ ho ban

☐ Eyintimefimepɛ mu gye to mu sɛmɛkadwumadiyi ho.

Nsɛmuanidini …….

Nhyɛase: …….. Ntimii ……

Bere: ……

Nsɛmisani din: ……..

Nhɛase: ……

Bere: ……..

Ekuw Din: Suapɔn Bath

Nhwehwemu : so mmɔborɔwaapɔmudendwumadi a wodisɛwodegyemmofra a wonni bi nkwa no etumi du wcnnkyɛn? Nhwehwɛ mu aefa ɔkwan a mpɔtam – mpɔtamapɔwmudenbetumpɔn wɔ Ghana.

Krataa a ɛfaonipa a ɔyɛnhwehwɛ mu yi ho

Wɔfrɛ me ɔbenfo Mary Nana AmaBrantuo. Medi me dwuma wɔ wiaseapɔwmudenkuwbaatanasoɛe wɔ Ghana.

Me namsaaadesuayi so benyamedwumadi mu abɔdinsɛ ɔbenfo wɔ apɔmuden mu na me nhwehwɛ mu yi no fammofraapɔwmudenne wɔn ayarehwɛ wɔ mpɔtam – mpɔtam.

Nhwehwɛ mu yibotae.

Nhwehwɛ mu yibɛhwɛ ɔkwan a yɛbɛfa so amampctam – mpɔtamapɔmudendwumadi no akɔ so ma abofrabiara a wohia no nsaatumi aka bi a ɛmfa ho ne beae a ɔwɔ hɔ.

Ne titioriwahiafo ne mmɔborɔwafo a wonnisika.Suahu a, ebefiadesuayimu aba no bɛboa ma y'ahwehwɛdwumadiahorowpii de aboammofra a wɔwɔ nkuraase ne mpɔtamaohiaadokorowɔn.

Akwankyeɛ

Dwumadiyi mu no yɛbɛhwɛnkrataa a ɛkyerɛmpɔtam no mpɔmudenyiediampɔmudennnwumayɛfo a wɔwɔ ɔman yimpɔmudebasoeɛe, mantam, mansin ne mpɔtam no nyinara de wɔnnhwehwɛ mu bɛtogua. Bio nso, yɛnewɔn a wodiiwɔndwuma wɔ mpɔtam – mpɔtam no ne wɔn a wodibano wɔ mpɔtamhɔnobetwetwenkɔmmɔ afadwumadi no ho.

ɔhaw ne Kɔdaɛnna

Nipa a wɔdewɔn ho bɛhyɛdwummadiyi mu no nnyaanidasomsɛwɔnbere a wɔdebɛma no pɛnaehiayɛn. saafo no bɛkawɔnnuanom a wagyeato mu dedaw no ho wɔ akuoahorow mu de agyewɔnadwenkyerɛ. Nsɛmisadwumadiyibedisimabɛyɛaduanananum de rekɔdɔnhwerebiakompo.

Mfaso:

ɛwɔmusɛhonamfa mu mfasobiaramfidwumadiyi mu mma de, nansow'ahofamabɛboa ma dwumadiyi de akwankyerɛ ne nhyehyɛe a ebetumiamammofraapɔmudenatumpɔn wɔ mpɔtam-mpɔtamayarehwɛ mu.

Mpata

Hu sɛmpatasikanni hɔ ma obiara a wɔde ne ho bɛhyɛsaadwumadiyi mu, nansosɛdwumadi no nyinaa kɔ wie a wodeanoneɛ bi bɛmasaaatuhoakyefoyi de adwodwowɔn ho.

Banbɔ

Yɛbɔ woanohomasɛ, nsɛmbiara a gyɛbɛgyewɔwohc no, yɛbɛbɔɛbɛbya erenkɔ nipafoforobiara hɔ, afeinsowɔde ne nyinaabeguadekorade mu ato mu safoa a onipa a dwumadiyisi ne nansonkotoonawokutasafoa no.

Ngyetom ne ntwesan

Obiara wɔ ho kwansɛ ɔbɛkadwumadiyi ho nasaaaransonaobiara wɔ ho kwansɛwɔtwe ne ho fi dwumadi no mu, kaesɛdwumadi no nnyɛ ɔhyɛntisɛwotwewo ho a nsusuansobɔnebiarammawoanaawo ho nipabiaraapɔwmudenhwɛahorownyinaa mu.

Nkitahodiakwankyerɛ

Oiara wɔ ho kwansɛ ɔkyerɛn'adwenanaawobisansɛmbiara a ɛdan'akoma so, mpompremprenyiara. Na sɛwopɛsɛwoka no baanunkɔmɔ nso a faakwankyereyi so;

Medaobiaraase

Atuhoakyefone wɔn a wodibano wɔ mpɔtamngye to mu krataa.

☐ Mankasamakenkannhyehyɛenwoma a woderedidwuma no anaa obi akenkanakyeɛ me ase wɔ me kasaa mu ma mate aseɛ.

☐ menyaakwanbisaansɛmfaaadesuayi ho ne neaɛdam'akoma so nyinaa ho, ma onyaaberekyerɛɛ me mu yie.

☐ ma mate asesɛ me tumiatwe me ho wɔ dwumadiyi mu a, enyansusuansobɔnebiarawo me anaa me ho nipabiaraapɔmudenhwɛ mu

☐ a wɔ hwɛsuapɔn Bath (university of Bath)adesuanhwehwɛ mu so amadwumadieyi ho kwan ma bagua Ghana apɔmudenasoeɛeapawwɔn no nsoagyeato mu

☐ ma mate asesɛwɔn a wɔɔyɛnhwehwɛ mu no nkotoonawobenyannsɛmisanwomanohoakwanyaahwɛ mu asanabɔ ho ban

☐ timefimepɛ mu gye to mu sɛmɛkadwumadiyi ho.

Nsɛmuanidini …….

Nhyɛase: …….. Ntimii ……

Bere: ……

Nsɛmisani din: ……..

Nhɛase: ……

Bere: ……..

Appendix 2: study approval letters

Letter of Approval from the University of Bath

Department for Health

UNIVERSITY OF BATH

Bath BA2 7AY · United Kingdom

Telephone +44 (0)1225 383461
Facsimile +44 (0)1225 383833
Email health@bath.ac.uk
www.bath.ac.uk/health

5 March 2014

Dear Mary,

Full title: Full title of study: How equitable are child survival interventions: A qualitative case study of Community Growth Promotion in Ghana

REACH reference number: EP 13/14 47

The Research Ethics Approval Committee for Health (REACH) reviewed the above application at its meeting held on 15th January 2014 .

On behalf of the Committee, I am pleased to confirm the amendments to the above research, on the basis described in the application form, were approved through Chair's action on 4th March 2014

Please inform REACH about any substantial amendments made to the study if they have ethical implications.

Letter of Approval from Ethical Review Committee

GHANA HEALTH SERVICE ETHICAL REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

My Ref. :GHS-ERC: 3
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: Hannah. Frimpong@ghsmail.org

24th April, 2014

Mary Nana Ama Brantuo
[redacted]

ETHICAL APPROVAL - ID NO: GHS-ERC: 11/11/13

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol titled:

"How equitable are child survival interventions: A qualitative case study of community growth promotion in Ghana"

This approval requires that you inform the Ethical Review Committee (ERC) when the study begins and provide Mid-term reports of the study to the Ethical Review Committee (ERC) for continuous review. The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Please note that any modification without ERC approval is rendered invalid.

You are also required to report all serious adverse events related to this study to the ERC within seven days verbally and fourteen days in writing.

You are requested to submit a final report on the study to assure the ERC that the project was implemented as per approved protocol. You are also to inform the ERC and your sponsor before any publication of the research findings.

Please always quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC VICE-CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

Letter of Approval from the Central Regional Directorate

GHANA HEALTH SERVICE

In case of the reply the number and the date of this letter should be quoted

GHANA HEALTH SERVICE
REGIONAL HEALTH DIRECTORATE
P.O BOX 63
CAPE COAST
CENTRAL REGION
GHANA

My Ref. No CR/Gr. 18/345
Your Ref. No

7th July, 2014

Tel. 03321 32281
Fax. 03321 34785
rhdcentralregion@yahoo.com

THE DISTRICT DIRECTORS
MFANTSIMAN DISTRICT
GOMOA EAST DISTRICT

LETTER OF INTRODUCTION

This to introduce Dr. Brantuo and her team of research assistant who will be visiting your district to collect data on a qualitative case study of community growth promotion towards the award of a professional doctorate health.

Kindly accord them with the necessary assistance they may need.

Find attached the Ethical approval.

Thank you.

DR. S. TETTEH KWASHIE
REGIONAL DIRECTOR OF HEALTH SERVICES
CENTRAL REGION

Appendix 3: Data Collection Tools

Interview Guide for National, Regional, District Level Health Staff

How are preventive child health services structured to reach the poor: A qualitative case study of Community Growth Promotion in Ghana.

Name..... Age.....Sex……
Profession.....Rank …….
Position..... How long have you held this position.....
Code: ……..

1. Can you tell me briefly what your work involves?
2. Can you tell me about any national policies or strategies you know which are aimed at improving health service to the poor?
3. How essential do you think such policies or strategies (refers to national pro-poor policies or strategies in question 2) are in improving health outcomes in your area of work?
4. How do you apply these policies and strategies (pro-poor) in your work?
5. Can you tell me what you know about the community growth promotion programme?
6. How are you involved in the community growth promotion programme?
7. Can you describe how the programme started at your level of operation?
8. What would you consider led to the start of the programme (Probe for key factors)
9. What do you understand to be the programme objectives?
10. To what extent do you consider community growth promotion to have met its objectives?
    a. Could you tell me some more?
    b. What is working well?
    c. What is not working very well?
11. How is community growth promotion being used to provide services to the poor?
12. Who do you consider the key players who need to be actively involved in this programme to ensure it reaches the poor?
13. To what extent have these key players been involved in the programme at its formulation and implementation stages?
14. What are the barriers to care for the poor and other marginalized groups?
15. What can be done to improve health services to the poor and marginalised?

Interview Guide for Sub-district Health Staff, Community Health Nurses, Community Health Officers and community volunteers

How are preventive child health services structured to reach the poor: A qualitative case study of Community Growth Promotion in Ghana.

Name.....Age.....Sex.....

Profession.....Rank …….

Position.....How long have you held this position.....?

Code:

1. Can you tell me about the health services you provide to the community?
2. Who are these services meant for within the community
3. Which community members use the services
4. What do you think about providing health services for the poor
5. How do the poor use the services you provide
6. Can you tell me what you know about the community growth promotion programme?
7. How are you involved in the community growth promotion programme?
8. Can you describe how the programme started at your level of operation?
9. What do you understand to be the programme objectives?
10. How is the programme being implemented?
    a. What is working well?
    b. What is not working very well?
11. What services do you provide in the package of community growth promotion?
12. How are people able to use the services provided?
    a. What barriers may prevent people from using the services?
13. How do you address these barriers?
14. What are the possible barriers that may prevent poor people from being able to use the services provided?
15. How do you think the community members and caregivers perceive the way that the services are provided?
16. Is there any way of making the services easy to use by the caregivers particularly those who are poor?

Interview Guide for community leaders

How are preventive child health services structured to reach the poor: A qualitative case study of Community Growth Promotion in Ghana.

Name..... Age …… Sex…….

Position in the community ……

How long have you held this position.....?

Code……

1. Who are considered the poor people in the community?
2. How can the poor be identified?
3. What problems do the poor people face when going for health services in hospitals, clinics, and in the community?
4. What do you know about the community programme for monitoring the growth of children?
5. What do you think of the services provided at the session for the health and growth of children?
6. How widespread is the use of the services among the community members?
   a. How are people able to use the services provided?
   b. What barriers may prevent caregivers from using the services?
7. What are the possible barriers that may prevent poor people from being able to use the services provided?
8. What do you think can be done to make it easier for caregivers to use the services?
9. What do you think can be done to make it easier for caregivers who are poor to use the services?
10. How willing are caregivers including the poor to use the services if it is made easier?

Discussion Guide for Caregivers

How are preventive child health services structured to reach the poor: A qualitative case study of Community Growth Promotion in Ghana.

1. What are the common jobs (common occupation) in this community?
2. Who are considered the poor people in this community?
3. How can these poor people be identified?
4. What problems do the poor people face when going for health services in hospitals, clinics, and in the community?
5. What problems do poor people face when the person seeking care is an adult;
6. What problems do poor people face when the person seeking care is a child accompanied by a caregiver?
7. What do you know about the community growth promotion programme?
8. What services do children receive at the community growth promotion session?
9. What do you think of the services provided at the session for the health and growth of children?
10. How widespread are these services among the community members?
    a. How are people able to use the services provided?
    b. What barriers may prevent you and other caregivers in the community from using the services?
    c. What are the possible barriers that may prevent poor people in the community from being able to use the services provided?
11. What can be done to make it easier for the caregivers to use the services.
12. What can be done to make it easier for the caregivers who are poor to use the services?
13. How willing are caregivers including the poor to use the services if it is made easier?

Appendix 4: Background characteristics of respondents

Table A-1 Characteristics of the participants in the in-depth interviews

Participants Code	Age	Sex	Profession	Rank	Position	Months / years in position
IDI-NA-01	53	M	Health Economist	Head of Policy	Deputy Director	3 years
IDI-NA-02		F	Nutritionist	Deputy Chief Nutrition Officer	Programme Manager	15 years
IDI-NA-03	48	M	Planner	Deputy Director	Deputy Director	10 years
IDI-NA-04	56	F	Nutritionist	Deputy Chief Nutrition Officer	Acting Deputy Director	Months
IDI-NA-05	58	M	Health Planner	Director	Health of Unit	3 years
IDI-RG-01	29	F	Nutritionist	Nutrition Officer	Regional Nutrition Officer	3 years
IDI-DS-GE-01	28	Female	Nutritionist	Nutrition Officer	District Nutrition Officer	2.5 years
IDI-DS-GE-02	51	Female	Public Health Nurse	Nursing Officer	District Public Health Nurse	3 years
IDI-SB-GE-01	31	Female	Physician Assistant	Physician Assistant	Facility in charge	2 years
IDI-CH-GE-01	27	Female	Community Health Nurse	Community Health Officer	Facility in Charge	5 months
IDI-CH-GE-02	24	Female	Community Health Nurse	Community Health Officer	Facility in Charge	
IDI-CL-GE-01	46	Male	-	-	Unit committee Chairman	4 year s
IDI-CL-GE-02	56	Male	-	-	Opinion Leader	20 years
IDI-CV-GE-01	62	Female	Farming	-	Community Volunteer	>10 years
IDI-CV-GE-02	28	Female	Farmer	-	Community volunteer	2 years
IDI-DS-MF-01	54	Female	Public Health Nurse	Deputy Director of Nursing Services	Municipal Public Health Nurse	4 years
IDI-DS-MF-02	52	Female	Public Health Nurse	Director of Health Services	District Health	5 years
IDI-SB-MF-01	27	Female	Community Health Nurse	Community Health Nurse	Facility in Charge	1 year
IDI-CH-MF-01	25	Female	Community Health Nurse	Community Health Nurse	Community Health Nurse	3years
IDI-CH-MF-02	29	Male	Community Health Nurse	Community Health Nurse	Reproductive and Child Health In Charge	6 months
IDI-CL-MF-01	33	Male	-	-	Assembly man	
IDI-CL-MF-02	67	Male	-	-	Opinion Leader	
IDI-CV-MF-01	70	Male	Farmer/Pastor	-	Community Volunteer	
IDI-CV-MF-02	28	Male	-	-	Community Volunteer	

Table A-2: Characteristics of Participants in the Focus Group Discussion - 1

Code FGDGE 01								
No of Caregiver	**Age of Caregiver**	**Education**	**Occupation**	**Marital status**	**Religion**	**Length of stay in community**	**Age of youngest child in your care**	**Relationship to caregiver**
1.	27	JHS	Hair dresser	Married	Jehovah Witness	Since Birth	6 months	Mother
2.	28	JHS	Farmer	Married	CAC	Since Birth	1 yr.	Mother
3.	20	JHS 2	Unemployed	Single	Christian	10yrs	1 yr. 10 months	Mother
4.	26	JHS	Trader	Married	Catholic	Since Birth	1 yr.	Mother
5.	31	JHS	Seamstress	Married	Pentecost	Since Birth	1 yr.	Mother
6.	26	JHS	Farmer	Single	Roman	Since Birth	2 months. 3 weeks	Mother
7.	34	JHS	Seamstress/Farmer	Married	Methodist	Since Birth	1 yr. 6 months	Mother
8.	32	JHS 2	Farmer	Divorced	Jehovah Witness	Since Birth	1 yr. 2months	Mother
9.	30	JHS	Hair dresser	Married	Roman	Since Birth	1yr. 8months	Mother

Table A-3: Characteristics of Participants in the Focus Group Discussion - 2

Code FGDGE 02								
No of Caregiver	**Age of Caregiver**	**Education**	**Occupation**	**Marital status**	**Religion**	**Length of stay in community**	**Age of youngest child in your care**	**Relationship of caregiver**
1.	23	JHS 1	Unemployed	Married	Christian	3yrs	2yrs	Mother
2.	25	JHS	Unemployed	single	Christian	3yrs	3yrs	Mother
3.	22	JHS 2	Unemployed	Divorced	Christian	Since Birth	1 and half yrs.	Mother
4.	39	SSS	Trader	Married	Christian	9yrs	1mnth	Mother
5.	30	JHS	Trader	Married	Christian	Since Birth	1yr	Mother
6.	32	JHS 2	Trader	Divorced	Christian	Since Birth	2yrs, 4mths	Mother
7.	23	JHS	Apprentice Seamstress	Married	Christian	More than 10yrs	3yrs	Mother
8.	37	JHS	Trader	Divorced	Christian	20yrs	more than 2yrs	Mother
9.	23	Class 6	Trader	Married	Christian	Since Birth	2yrs	Mother

Table A-4: Characteristics of Participants in the Focus Group Discussion - 3

Code FGD-MF-01								
No of Caregiver	**Age of Caregiver (in yrs.)**	**Education**	**Occupation**	**Marital status**	**Religion**	**Length of stay in community**	**Age of youngest child in your care**	**Relationship to caregiver**
1.	25	Primary 6	Dressmaker	Married	Christian	25yrs	2mnths	Mother
2.	20	JHS 2	Trader	Married	Christian	15yrs	3mnths	Mother
3.	33	JHS 3	Dressmaker	Married	Christian	20yrs	2yrs	Mother
4.	20	JHS 1	Trader	Married	Christian	2yrs +	1yr	Mother
5.	38	Primary 4	Hairdresser	Married	Christian	34yrs	2mnths	Mother
6.	36	Primary 3	Seamstress	Married	Christian	3yrs	5mnths	Mother
7.	25	Nil	Fishmonger	Married	Christian	**	**	**
8.	29	JHS 3	Seamstress	Married	Christian	20yrs	3yrs	Mother
9.	24	Nil	Trader	Married	Christian	24yrs	4 and half months	Mother

Table A-5: Characteristics of Participants in the Focus Group Discussion - 4

Code FGD-MF-02								
No of Caregiver	**Age of Caregiver (in yrs.)**	**Education**	**Occupation**	**Marital status**	**Religion**	**Length of stay in community**	**Age of youngest child in your care**	**Relationship to caregiver**
	46	Primary 4	Farmer	Married	Christian	13yrs	1yr	Mother
2.	38	Primary 6	Seamstress	Married	Christian	20yrs	1yr 1mnth	Mother
3.	20	JHS 2	Unemployed	Single	Christian	Since Birth	1yr 3mnths	Mother
4.	30	Vocational	Seamstress	Widow	Christian	8yrs	1 and half yrs.	Mother
5.	22	Primary 6	Unemployed	Divorced	Christian	3yrs	1yr 1mnth	Mother
6.	41	Primary 6	Farmer	Married	Christian	22yrs	1yr	Mother
7.	29	JHS 1	Food Vender (Cooked Food)	Married	Christian	Since Birth	1 and half yrs.	Mother
8.	21	Primary 6	Unemployed	Married	Christian	Since Birth	5mnths	Mother
9.	20	JHS	Unemployed	Married	Christian	Since Birth	2yrs 5mnths	Mother

Appendix 5: Expanded Thematic Framework

Table A-6: Expanded Thematic Framework

Question	CODE		DESCRIPTION (Responses provided in the transcripts)
	1.0	Dimensions of equity issues in the community growth promotion programme in Ghana.	
	1.1	Philosophy of Equity	
What do you think about providing health services for the poor? How do the poor use the services you provide?	**1.1.1**	Equity in service delivery/Reaching the poor with health services	Perception of provision of health services for the poor, descriptions of health services to the poor
Do you know any national policies or strategies you know that are aimed at improving health services to the poor?	**1.1.2**	Pro-poor Health Policies -	Perception of National policies or Various approaches that are considered pro-poor such as Community approach, Universal access increasing financial access (Health insurance, Exemption policies) Services close to clients, programmes targeting hard to reach areas or targeting deprived district, Social interventions - LEAP, Addressing and monitoring indicators of inequity
How essential do you think such policies or strategies (refers to national pro-poor policies or strategies) are in improving health outcomes in your area of work? How do you apply these policies and strategies (pro-poor) in your work?	**1.1.3**	Relevance of Pro-poor policies	Perceived relevance, application and benefits of national policies on poverty such as in Planning, Resource allocation, prioritization, increase in access, achieving health outcomes, universal coverage, community participation, identifying deprived communities
	2.0	Experience of implementing community growth promotion focusing on poor and marginalized.	
Can you describe how the CGP programme started at your level of operation? What would you consider led to the start of the programme (Probe for key factors)	**2.1**	Agenda setting - Initiating CGP	Key factors considered in the decision and prioritizing of CGP, such as disease or malnutrition burden, access to care, criteria for selection of regions, districts, communities for implementation.

To what extent do you consider community growth promotion to have met its objectives?	**2.2**	Benefits of CGP	Perceived CGP benefits such as community ownership, critical link in service delivery and the continuum of care, provision of comprehensive service, entry point for other interventions, access of formal health workers to better knowledge of community, multi-tasking of volunteers
Can you tell me what you know about the community growth promotion programme? How are you involved in the community growth promotion programme? What services do you provide in the package of community growth promotion? How do you think the community members and caregivers perceive the way that the services are provided?	2.3 2.3. 1 knowledge 2.3.2 participation 2.3.3 Services provided 2.3.4 perception of community members	CGP Services	Perception and description of services provided by community growth
How is community growth promotion being used to provide services to the poor? Who do you consider the key players who need to be actively involved in this programme to ensure it reaches the poor? Is there any way of making the services easy to use by the caregivers particularly those who are poor?	**2.4**	CGP Services to the Poor	How the poor benefit from the services provided, such as no need for transport to access service
What do you understand to be the programme objectives? To what extent have these key players been involved in the programme at its formulation and implementation stages?	**2.5**	Formulation of CGP	Objectives of CGP such as Technically to improve nutrition, to Improve participation

To what extent have these key players been involved in the programme at its formulation and implementation stages?	**2.6**	Roles played by different actors	Description of the different roles – e.g. other sectors such as community development to determine who needs the service, Ministry of Health at National, regional, district levels involved in Resource mobilization, targeting and supervision, implementation Community level - Committees, Traditional leaders as Advocates, Assembly men, Faith groups
	2.6.1	Roles of health care workers	
	2.6.2	Roles of other sectors	
	2.6.3	Roles of the community	
	2.6.4	Roles of the ministry of health and national, regional district	
	2.6.5	Roles of volunteers	
Who do you consider the key players who need to be actively involved in this programme to ensure it reaches the poor?	**2.7**	Stakeholders' Experience	Experience of stakeholders in service delivery (e.g. volunteers - Community mobilisers sacrificial nature of work, Community appreciation and trust, pride in their role, anger against those who do not appreciate their work)
	2.7.1	Experiences of health workers	
	2.7.2	Experiences of the caregivers who utilise the services	
	2.7.3	Experiences of volunteers	
How can the programme be improved	**2.8**	Sustaining services at the Community level	Perceived approaches required for sustained service delivery at community level such as allocation of resource allocation, community engagement and participation, avoidance of parallel systems,
How are people able to use the services provided?	**2.9** **2.9.1 barriers**	Utilisation of services	Barriers affecting utilisation of services such as times clashing with income-generating

What barriers may prevent people from using the services? How do you address these barriers?	**2.9. 2 addressing barriers**		activities, embarrassment of caregivers when child is not growing well, when caregivers do not have appropriate clothes, poor attitude of health workers, out of pocket payments,
	3.0	To understand the factors that influences the uptake of the intervention among the poor at community level.	
What are the barriers to care for the poor and other marginalized groups? What problems do the poor people face when going for health services in hospitals, clinics, and in the community?	**3.1**	Barriers to care for the poor	Barriers to care for the poor such as cultural, financial, geographical, gender, illiteracy, intimidating formal health care system,
Who are considered the poor people in the community? How can the poor be identified?	**3.2**	Defining Poverty	Criteria of poverty such local identification of deprivation, pockets of deprivation, Seasonal / fluctuating/temporary nature of poverty, community health workers' observation of social factors in communities, vulnerability a measure of poverty, people who cannot come close to health services, remoteness of community, burden of disease, Occupation in the community
What are the barriers to care for the poor and other marginalized groups?	**3.3**	Health System challenges in reaching the poor	Challenges with operationalizing pro-poor policies and interventions, Health system challenges in reaching the poor such as limited resources in service delivery to the poor, not defining the scope and areas of need, low motivation in reaching poor when coverage of interventions is high, instability in poor communities
What can be done to improve health services to the poor and marginalised How willing are caregivers including the poor to use the services if it is made easier?	**3.4** **3.4.1 willingness to use service**	Improving care for the poor	Ways of improving care to the poor such as targeting of the poor, Client friendly services, Community empowerment, Integration of services addressing the poor, Availability of Human resources in poor or deprived areas Willingness of the caregivers to utilise services